Presbyterian Health Plan

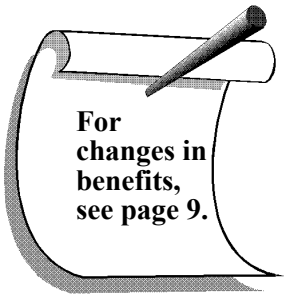
http://www.phs.org

2012

A Health Maintenance Organization (High option)

Serving: *All counties of New Mexico*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

High Option

- P21 Self Only
- P22 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Presbyterian Health Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that Presbyterian Health Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is consdered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Presbyterian Health Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop our coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227) (TTY) 1-877-486-2048.

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Introduction

This brochure describes the benefits of Presbyterian Health Plan under our contract (CS 2627) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Presbyterian Health Plan's administrative offices is:

Presbyterian Health Plan

2501 Buena Vista SE

Albuquerque, NM 87106

Or

P.O. Box 27489

Albuquerque, NM 87125-7489

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples.

- Except for necessary technical terms, we use common words. For instance, "You" means the enrollee or family member, "We" means Presbyterian Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefit plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statement that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 505/923-5678 or toll-free 1-800-356-2219 or TTY for the hearing impaired at 505/923-5699 or toll-free at 1-877-298-7407 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1.Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2.Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3.Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4.Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5.Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer . The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org . The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/ . The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org . The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org . The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Presbyterian Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the liklihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan or you will incur cost to correct the medical error.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurances described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

This plan is a "grandfathered" health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed –dollar amount you pay) must be minimal.

Questions regarding what protections do not apply to a non-grandfathered health plan may be directed to us at 1-800-356-2219, or write to Presbyterian Health Plan, P.O. Box 27489, Albuquerque, NM 87125-7489. For the hearing impaired, call our TTY line at 505-923-5699 or toll-free at 1-877-298-7407. You may also contact us by fax at 505-923-8163 or visit our Web site at www.phs.org. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Options

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Our Fee Schedule is based on the Resource Base Relative Value Scale (RBRVS). The RBRVS method was designed by physicians to fairly compensate themselves based on:

1. a nationally uniform relative value for service;
2. geographic adjustment factor; and
3. a nationally uniform conversion factor for service.

This method has been adopted by our Federal Centers for Medicare and Medicaid Services for Medicare reimbursement.

The RBRVS pays higher for evaluation and management services and lower for procedures. All physicians receive reimbursement for both evaluation and management services and procedures. The effect upon the individual physican will vary depending upon how much time they spend in office-based services as compared to procedural-based services.

Typically, physicians such as primary care physicians, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office-based services, and physicians such as surgerons, and cardiologists spend more time in procedure-based services. Although this fee schedule is both provider and health plan based, it results in a high quality health plan for you and your families.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Presbyterian Health Plan (a for profit organization) is owned by Presbyterian Healthcare Services (a non-profit organization), which has been providing quality care for New Mexicans since 1908.
- As part of Presbyterian Healthcare Services, the health plan represents an organization with over 100 years of community service to New Mexicans.
- Customer Satisfaction Measures
- Networks and Providers

If you want more information about us, call 800-356-2219, or write to Presbyterian Health Plan, P.O. Box 27489, Albuquerque, NM 87125-7489. For the hearing impaired, call our TTY line at 505-923-5699 or toll-free 1-877-298-7407. You may also contact us by fax at 505-923-8163 or visit our Web site at www.phs.org.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area includes all counties of New Mexico.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office. Full-Time dependent students attending school outside Presbyterian Health Plan's service area can receive care at a Student Health Center without a preauthorization from their Primary Care Physician. Services provided outside of the Student Health Center are for medically necessary services for the initial care or treatment of an Emergency or Urgent Care situation.

Section 2 How we change for 2012

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide Change

- **Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordability Care Act, Public Law 111-148.**

Changes to this Plan• Your share of the non-Postal premium will decrease for Self Only and for Self and Family.

- **Adult Urgent Care copayment changing from $25 for participating provider and $35 for non-participating provider to $40 copayment for in or out of-network. •Emergency Room copayment changing from $75 copayment to $100 copayment (in or out of-network). •Services provided by a hospital or other facility changing from $350 copayment per admission to $100 per day up to 5 days per admission. •Specialty Drugs changing from 15% up to a max of $250 with out-of-pocket max if $1,500 to 25% up to a max of $250 with out-of-pocket max of $2,000 per calendar year.•Retail prescription drug copayments per prescription are as follows:-Tier 1 – Preferred Generic Drugs copayment remains $10-Tier 2 – Preferred Brand Drugs copayment is now $40 instead of $30-Tier 3 – Non-Preferred Drugs copayment is now $75 instead of $50 •Mail Order prescription drug copayments per prescription are as follows:-Tier 1 – Preferred Generic Drugs copayment remains $20-Tier 2 – Preferred Brand Drugs copayment is now $80 instead of $60-Tier 3 – Non-Preferred Drugs copayment is now $150 instead of $100**

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 505-923-5658 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407. You may write to us at P.O. Box 27489, Albuquerque, NM 87125 You may also request replacement cards through our Web site at www.phs.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We obtain, verify, review, and evaluate practitioners' competencies and qualifications on an ongoing basis to determine whether they can participate as providers in our Plan. Providers we credential include medical doctors, specialists, physician assistants, certified nurse practitioners, licensed social workers, and licensed professional counselors.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. The listings are first organized by region within New Mexico – Central New Mexico, Northern New Mexico, and Southern New Mexico. Each region, physicians, other providers, and facilities are organized by primary care physicians are listed as family practice, general practice, internal medicine, pediatrics, and OB/GYN's acting as PCPs.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site. The list is also on our Web site. Presbyterian Health Plan's provider directory has a section that lists all participating facilities, hospitals, and pharmacies across the state.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must select a primary care physician from the PHP provider directory. Locations and telephone numbers of the participating doctors are listed in the PHP provider directory or can be obtained by calling the Presbyterian Customer Service Center at 505-923-5678 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 or by accessing our website at www.phs.org. By selecting a PCP who belongs to the plan, members are selecting their corresponding network of specialists, hospitals, and other providers to serve their healthcare needs. A PCP selection form is in your packet. Select your provider by the 5-digit provider number and mail it in the return envelope. Should you choose to change your PCP your requested change will be effective the next business day following your request.

- **Primary care**

Your primary care physician can be a family practice, general practice, internal medicine, pediatrics, and OB/GYN (if applicable) acting as a primary care physician. Your primary care physician will provide most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one

- **Specialty care**

  - You may receive specialty services from Plan physicians without a referral.
  - Even though you may see a specialist without referral, certain procedures and services may require prior authorization by Presbyterian Health Plan.
  - Services of a non-Plan physician will not be covered unless precertification is obtained prior to receiving the services. You may be liable for charges resulting from failure to obtain precertification for services provided by the non-Plan physician, except for urgent or emergent services.
  - If you are seeing a specialist and your specialist leaves the Plan, call us to assist You in finding another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
  - If you have a chronic and disabling condition and lose access to your specialist because we:
    - terminate our contract with your specialist for other than cause; or
    - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
    - reduce our service area and you enroll in another FEHB Plan.

  You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

  If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

  Your primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Center immediately at 1-800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 505-923-5699 or 1-877-298-7407. If you are new to the FEHB Program, we will arrange for you to receive and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

  If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

  - you are discharged, not merely moved to an alternative care center; or
  - the day your benefits from your former plan run out; or
  - the 92nd day after you become a member of this Plan, whichever happens first.

  These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

  Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary and follows generally accepted medical practice.

Certain services require approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for services such as, but not limited to: Durable Medical Equipment, Hospice, Acute Rehabilitation, Outpatient Rehab, Skilled Nursing Facilities, Hospitalization and Mental Health/Substance Abuse care.

Except in medical emergency you must obtain pre-authorization prior to seeing a non-Plan physician. Your Plan physician must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan physician must request and obtain written authorization from the Presbyterian Health Plan Medical Director before you may receive services.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative must call us at 1-800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 505-923-5699 or 1-877-298-7407 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a caesarean section, then you, your representative, your physician or the hospital must contact us on precertification of additional days. Further, if your baby stays after you are discharged, then you, your representative, your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours.

What happens when you do not follow the precertification rules when using non-network facilities

Certain services require approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for services such as, but not limited to: Durable Medical Equipment, Hospice, Acute Rehabilitation, Outpatient Rehab, Skilled Nursing Facilities, Hospitalization and Mental Health/Substance Abuse care.

Except in a medical emergency you must obtain pre-authorization prior to seeing a non-Plan physician. Your Plan physician must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan physician must request and obtain written authorization from the Presbyterian Health Plan Medical Director before you may receive services.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

Your or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 month of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your consideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4 Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician **for non-preventive services**, you pay a copayment of $25 per office visit and when you go see a specialist, you pay a copayment of $35 per office visit . When you see your primary care physician **for preventive services**, you pay nothing for the office visit and when you go see a specialist, you pay a copayment of $25 for adult and $15 for children per office visit . When you go in the hospital, you pay $100 copayment per day up to 5 days per admission.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. coinsurance and copayment(s) for the covered care you receive.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for infertility services and 30% of our allowable for durable medical equipment.
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurance) total $2000 per person or $4000 per family enrollment in any Calendar year, You do not have to pay any more for Covered services. However, copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services: • Prescription drugs • Dental services • Vision services • Non-covered charges Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to see reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek mor than their governing laws allow. You may be responsible for certain services and charges. Contact the government facility directly for more information.

Section 5 High Option Benefits

See page 9 for how benefits changed this year. Page 77 is a benefits summary of the High option. Make sure you review the benefits that are available in which you are enrolled.

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Section 5 High Option Benefits Overview

This Plan offers a High Option only. This benefit package is described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about the High Option benefits, contact us by calling our Customer Service Center at 505-923-5678 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 or by accessing our website at www.phs.org.

The High option offers unique features.

High Option The High Option covers most services subject to a copayment. See Section 5 for plan specifics.	

Section 5(a) Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • Primary Care Physician • Specialist	$25 copayment per visit $0 copayment per visit for children up to age 26 $35 copayment per visit $15 copayment per visit for children up to age 26 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)
Professional services of physicians • In an urgent care center	$40 copayment for participating providers $10 copayment for children up to age 26 for participating providers $40 copayment for non-participating providers $15 copayment for children up to age 26 for non-participating providers
• During a hospital stay	$100/day copayment per admission (inpatient) up to 5 days (Physician services do not have an additional copayment as the service charges are included in the inpatient hospital/facility admission copayment) $150 copayment per visit (outpatient) (included in hospital/facility outpatient copayment)
• Office medical consultation	$25 copayment per visit to primary care physician $0 copayment per visit for children up to age 26 $35 copayment per visit to specialist $15 copayment per visit to specialist for children up to age 26
• In a Skilled Nursing Facility: Admission must be arranged and preauthorized by the Plan. Skilled Nursing Facility care is provided for up to 60 days per member, *per Calendar year*	$100/day copayment per admission up to 5 days (Physician charges are included in the inpatient hospital/facility admission copayment)
At home	$25 copayment per visit by a primary care physician

Diagnostic and treatment services - continued on next page

Benefit Description	You pay
Diagnostic and treatment services (cont.)	**High Option**
	$35 copayment per visit by a specialist
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Diagnostic tests are not subject to a copayment regardless of whether an office visit is billed. If an office visit is billed, the following copayments are taken: $25 copayment per visit to primary care physician $35 copayment per visit to specialist
Computed Axial Tomography (CAT) scans/Magnetic Resonance Imaging (MRI) tests/Positron Emission Topography (PET) scans	$100 copayment per test
Sleep Studies – Outpatient overnight stay without admission	$100 copayment per test
Sleep Studies – Outpatient overnight stay with admission	$100/day copayment per admission up to 5 days
Preventive care, adult	**High Option**

Routine screenings, such as:
Preventive physical exam
Office based health education
Glaucoma testing
Family planning
Blood lead level - one annually
• Total Blood Cholesterol - once every three years
• Osteoporosis Screening
• Colorectal Cancer Screening, including
  • Fecal occult blood test
  • Sigmoidoscopy, screening – every five years starting at age 50
  • Double contrast barium enema – every five years starting at age 50
  • Colonoscopy screening – every ten years starting at age 50
	Nothing

Routine screenings, such as: • Chlamydia infection	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Routine Pap test	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Human papillomavirus screening – every three years starting at age 30 Note: The office visit is covered if pap test or human papillomavirus screening is received on the same day, see *Diagnostic and treatment services,* above.	Nothing
Routine mammogram • From age 35 through 39, one during this five year period • From age 40 through 64, one every Calendar year • At age 65 and older, one every two consecutive Calendar years	Nothing
Adult routine immunizations, endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing

• Well-child care charges for routine examinations, immunizations and care (up to age 26)
• Examinations, such as:
  • Eye exams through age 17 to determine the need for vision correction
  • Ear exams through age 17 to determine the need for hearing correction
  • Examinations done on the day of immunizations (up to age 26)
	Nothing

Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	$25 copayment per visit up to a maximum of $150 per pregnancy Specialists (Perinatologist) - $35 copayment per visit Delivery – Inpatient - $100/day copayment per admission up to 5 days (included in inpatient hospital/facility inpatient admission copayment)

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	$25 copayment per visit up to a maximum of $150 per pregnancy Specialists (Perinatologist) - $35 copayment per visit Delivery – Inpatient - $100/day copayment per admission up to 5 days (included in inpatient hospital/facility inpatient admission copayment)
Not covered: *Circumcisions performed other than during the newborn Hospital stay are only Covered when Medically Necessary.*	*All charges*
Family planning	**High Option**
A broad range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) · Surgically implanted contraceptives (Such as Norplant) • Intrauterine devices (IUDs) · Diaphragms Note: We cover oral contraceptives and injectable contraceptive drugs (such as Depo Provera) under the prescription drug benefit.	Outpatient – $150 copayment per visit (included in hospital/facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in Hospital/facility admission copayment) Insertion procedure only: 50% of all charges $25 copayment per visit to primary care physician $35 copayment per visit to specialist No additional copayment if office visit copayment is already taken. 50% of all charges $25 copayment per visit to primary care physician $35 copayment per visit to specialist No additional copayment if office visit copayment is already taken.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) Artificial insemination is covered up to 3 inseminations. • Fertility drugs	$25 copayment per visit to primary care physician $35 copayment per visit to specialist 50% of all charges 50% of all charges

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  • *in vitro fertilization*
  • *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)*
• *Services and supplies related to ART procedures*
• *Cost of donor sperm*
• *Cost of donor egg.*
	All charges.

Allergy care	**High Option**
• Testing and treatment	$25 copayment per visit to primary care physician $0 copayment for children up to age 26 for participating providers $35 copayment per visit to specialist $15 copayment for children up to agee 26 for specialist
• Allergy injections	Allergy injections are included in the office visit copayment. If there is no office visit, allergy injections are not subject to a copayment. (waived if nursing visit only)
• Allergy serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**High Option**
• Radiation therapy	Nothing
• Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	$35 copayment per visit to specialist
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Chemotherapy	25% of all charges up to a maximum of $250 per prescription/ infusion and $2,000 per Calendar Year
Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 33.	
• Specialty Pharmaceuticals (see also Home health services) – Oral or inhalation forms/Self-administered • Specialty Pharmaceuticals – Intravenous (IV)	
• Growth hormone therapy (GHT)	25% of all charges up to a maximum of $250 per prescription/ infusion and $2,000 per Calendar Year

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services fand related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 14.	25% of all charges up to a maximum of $250 per prescription/ infusion and $2,000 per Calendar Year
Physical and occupational therapies	**High Option**
Provided in patient or out-patient up to 2 months per condition if significant improvement is expected for the services of each of the following: • qualified physical therapists; and • occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. In-patient or out-patient therapy may be extended 2 additional months if significant improvement is expected to continue and must be preauthorized by PHP. Autism Spectrum Disorders are not subject to these limitations for children up to age 26. Significant improvement means: • The patient is likely to meet all therapy goals for the first two months of therapy; or • The patient has met all therapy goals in the preceding two months of therapy, as specifically documented in the therapy record.	$35 copayment per visit
This benefit is *not* renewable each Calendar year.	$35 copayment per visit
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions with continuous electrocardiogram (ECG) monitoring and up to 24 sessions with intermittent ECG monitoring at an approved facility.	
Not covered: • *Long-term rehabilitative therapy includes treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. Chronic conditions include, but are not limited to Muscular Dystrophy, Down's Syndrome, and Cerebral Palsy. (Any therapy beyond 4 consecutive months is defined as long term therapy.)* • *Exercise programs*	*All charges.*

Benefit Description	You pay
Speech therapies	**High Option**
Speech Therapy is covered for up to 2 months when provided by a licensed or certified speech therapist subject to the following: • Speech Therapy is medically necessary • Speech Therapy *must be* preauthorized by us • Following the initial 2 months of treatment, in-patient or outpatient Speech Therapy may be extended for a period not to exceed 2 additional 2-month periods. Autism Spectrum Disorder is not subject to these limitations for children up to age 26.	$35 copayment per visit
Not covered: *Speech Therapy beyond 6 consecutive months.*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by and M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit see Section 5(a) *Preventive care, children*	$15 copayment per visit to primary care physician $25 copayment per visit to specialist
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	$15 copayment per visit to primary care physician $25 copayment per visit to specialist
• Hearing testing for children through age 26 *(See Preventive care, children)*	$0 copayment per visit to primary care physician $25 copayment per visit to specialist
Not covered: All other hearing testing • *Hearing aids batteries* • *Hearing aids, testing and examinations for hearing aids* • *Hearing servises that are not shown as covered*	*All charges.*

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	**High Option**
• Eye exam to determine the need for vision correction for children through age 26 (see Preventive care, children)	$0 copayment per visit to primary care physician $15 copayment per visit to specialist
• One Eye refraction per year for children under 6 when medically necessary to aid in the diagnosis of certain eye diseases	$0 copayment per visit to primary care physician $15 copayment per visit to specialist
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	30% of all charges
Not covered: • *Eyeglasses or contact lenses and after age 26, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Replacement of all items referenced in this section due to loss, neglect, theft, misuse, abuse or for convenience.*	*All charges.*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$25 copayment per visit to primary care physician $35 copayment per visit to specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) • Corrective orthodontic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	30% of all charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**High Option**
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	30% of all charges
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices, except for gradient compression hose* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Speech synthesis devices*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotics Devices is Covered when Preauthorized by PHP and when Medically Necessary due to change in the member's condition, wear or after the product's normal life expectancy has been reached.	30% of all charges
Not covered: • *Deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.*	*All charges.*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience is **not Covered**. Repair and replacement of items under the manufacturer or supplier's warranty is **not Covered.** If the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair, additional wheelchair(s) are **not Covered.** One-month rental of a wheelchair is Covered if a Member owned wheelchair is being repaired.*	*All charges.*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide and pre-authorized by us. • Services include oxygen therapy, intravenous therapy and medications.	Nothing

• Specialty Pharmaceuticals (see also Treatment therapies page 23)
  • Oral or inhalation forms/Self-administered
  • Intravenous (IV)
	25% of all charges up to a maximum of $250 per prescription/ infustion and $2,000 per Calendar Year

Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic	**High Option**
Chiropractic Services – 18 visits per year if medically necessary. • Your Plan physician must determine that your treatment will result in significant improvement in your condition within 2 months • Chiropractic treatment is specifically limited to treatment by means of manual manipulation, by the use of hands, and ultrasound therapy • Subluxation must be documented by chiropractic examination and documented in the chiropractic records • Chiropractic x-rays are only covered when performed by a chiropractor for the following clinical situations, unless clinically relevant x-rays already exist:	$35 copayment per office visit

Chiropractic - continued on next page

Benefit Description	You pay
Chiropractic (cont.)	**High Option**
• Acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents • Clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over ½ inch, or spine curvature consistent with osteoporotic fractures; or • Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$35 copayment per office visit
Not covered: • *Chiropractic treatment for chronic subluxation or rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions.* *Rolfing* *Massage therapy* *Naturopathic services* *Hypnotherapy*	*All charges.*
Alternative treatments	**High Option**
Acupuncture – 20 visits per year if determined medically necessary by a doctor of medicine or osteopathy, for anesthesia, tobacco cessation or chronic or acute pain Acupuncture treatment for other medical conditions will be covered only if the following conditions are met: There is evidence-based medical literature that clearly supports the safety, efficacy and appropriateness of this treatment for the specific medical condition for which authorization is requested -Acupuncture must be part of a coordinated plan of care Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence	$35 copayment per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy*	*All charges.*

Benefit Description	You pay
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	*No copayment for educational classes and programs. Regular plan benefits apply to medical services.* *No copayment for tobacco cessation drugs in conjunction with Tobacco Cessation Program.*
Not covered: • *Hypnotherapy* • *Over the counter drugs* • *Acupuncture is not covered under the Tobacco Cessation Counseling benefit. However, acupuncture for tobacco cessation is covered under the acupuncture benefit subject to the acupuncture copayment and benefit limitation*	*All charges*

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Note: Refer to our Web site www.phs.org for more information regarding coverage and exclusion criteria. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in hospital/ facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in hospital/ facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Not covered: • *Reversal of voluntary sterilization* *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonable be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/ facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• *Surgeries related to sex transformation* *Claims incurred due to complications of elective cosmetic surgery*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures; • TMJ benefit (Limited)– Please refer to Section 5 (h) Dental Benefits.	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/ facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Not covered • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**

These **solid organ transplants** are covered. Solid organ transplants are limited to:
• Cornea
• Heart
• Heart/lung
• Intestinal transplants
  • Small intestine
  • Small intestine with the liver
  • Small intestine with multiple organs, such as the liver, stomach and pancreas
• Kidney
• Liver
• Lung: single/bilateral
• Pancreas
• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis.
	Office visit –
	
	$25 copayment per visit to primary care physician
	
	$35 copayment per visit to specialist
	
	Outpatient - $150 copayment per visit (included in the hospital/ facility outpatient copayment)
	
	Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**

These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures.
• Autologous tandem transplants for
  • AL Amyloidosis
  • Multiple myeloma (de novo and treated)
  • Recurrent germ cell tumors (including testicular cancer)
 	
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.
• Allogeneic transplants for
  • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
  • Advanced Hodgkin's lymphoma with reoccurrence (relapsed)
  • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)
  • Acute myeloid leukemias
  • Advanced Myeloprolifertive Disorders (MPDs)
  • Advanced neuroblastoma
  • Amyloidosis
  • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
  • Hemoglobiopathy
  • Infantile malignant osteopetrosis
  • Kostmann's syndrome
  • Leukocyte adhesion deficiencies
  • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)
  • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)
  • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants)
  • Myelodysplasia/Myelodysplastic syndromes
  • Paraxysmal Nocturnal Hemoglobinuria
	Office visit –
	
	$25 copayment per visit to primary care physician
	
	$35 copayment per visit to specialist
	
	Outpatient - $150 copayment per visit (included in the hospital/facility outpatient copayment)
	
	Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome • Autologous transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Autologous transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurrence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) • Amyloidosis • Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic tranplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyoarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
National Transplant Program (NTP) – All organ transplants must be medically necessary. Transplants will be performed at a site approved by us. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. The Plan will pay reasonable and customary charges for hospital, surgical, laboratory and x-ray services for a donor who is not entitled to benefits under any other health benefit plan or policy. Donor charges must result from the medically necessary covered transplant of an organ or body tissue to a member of the Plan. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. Limited travel benefits are available for the transplant recipient and one other person. Transportation costs will be covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be covered for both out-of-state and in-state, up to a maximum of $150 a day for both combined. All benefits for transportation, lodging and meals are limited to a maximum of $10,000.	Office visit – $25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/facility outpatient copayment) Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Not covered: • *Donor screening tests and donor search expenses, except for those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	Inpatient - $100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$25 copayment per visit to primary care physician $35 copayment per visit to specialist Outpatient - $150 copayment per visit (included in the hospital/facility outpatient copayment)

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100/day copayment per admission up to 5 days
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$150 copayment per visit
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): 60 days per member per Calendar year Note: We cover Room and board and other necessary services that you require and a SNF provides. The Plan must preauthorize the services that your Plan physician recommends	$100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Not covered: Custodial care or domiciliary care	*All Charges.*
Hospice care	**High Option**
The following services are covered for in-patient and in-home hospice benefits • Inpatient hospice care • Physician visits by plan hospice physicians • Home health care by approved home health care personnel • Physical therapy • Medical supplies • Drugs and medication for the terminally ill patient	$100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
• Respite care for a period not to exceed five continuous days for every 60 days of hospice care. Only two respite cares are available during a hospice benefit period Benefits are provided for in a Plan hospice or facility approved by the plan physician and preauthorized by the plan. The hospice benefit period must begin while you are covered with this benefit, and coverage through the plan must be continued throughout the benefit period in order for hospice benefits to continue. The hospice benefits period is defined as: Beginning on the date the plan physician certifies that you are terminally ill with a life expectancy of six months or less; and ending six months after it began, or upon death. If you require an extension of the hospice benefit period, the hospice must provide a new treatment plan and the plan physician must recertify your medical condition to us. No more than one additional hospice benefit period will be preauthorized by us.	$100/day copayment per admission up to 5 days (included in hospital/facility inpatient admission copayment)
Not covered: • *Food, housing and delivered meals* Volunteer services Comfort items Homemaker and housekeeping services Private duty nursing *Pastoral and spiritual counseling and* *Bereavement counseling*	*All Charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	$50 copayment per occurrence
Ground Ambulance Air ambulance	$100 copayment per occurrence

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you need emergency care you should call 911 or seek treatment at the nearest emergency room. If in need of urgent care, you should seek treatment at an urgent care center that is open and available for business. Please note that some urgent care centers are not open after 8:00 p.m. In such circumstances, you many need to use an emergency room for care that is needed on an urgent basis.

Acute emergency medical care is covered 24 hours per day, seven days per week for services needed immediately to prevent jeopardy to your health. If you cannot reasonably access a plan facility, we will make arrangements to cover your care that is needed on an urgent basis.

Coverage for services will continue until you are medically suitable, do not require critical care, and can be safely transferred to a hospital in our plan network.

We will provide reimbursement when you, acting in good faith, obtain emergency care for what appears to you acting as a reasonable lay person, to be an acute condition that requires immediate medical attention, even if your condition is subsequently determined to be non-emergent.

In determining whether you acted as a “reasonable layperson” we determine the following factors:

- Your belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- The time of day the care was provided
- The presenting symptoms
- Any circumstances that prevented you from using our established procedures for obtaining emergency care

We will not deny a claim for emergency care when you are preauthorized to the emergency room by a plan doctor or the plan.

No prior preauthorization is required for emergency care.

If your emergency care results in a hospitalization directly from the emergency room the emergency co-payment is waived.

Emergencies within our service area

You should seek medical treatment from Plan providers whenever possible. Follow up care from Plan or non-Plan providers within the service area requires a preauthorization from a Plan provider.

Out-of-network emergency care will be provided to you without additional cost. The reasonable lay person standard from above will apply to determine if out of network care was appropriate.

Emergencies outside our service area

You may seek services from the nearest facility where emergency treatment can be provided. Non-emergent follow up care outside the service area is not covered unless transfer to a Plan provider would be medically inappropriate and a risk to your health. Non-emergent follow-up care outside of our service area is not covered for convenience or preference.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$25 copayment per visit to primary care physician
Professional services of physician	$35 copayment per visit to specialist $40 copayment per visit for participating providers
• In an urgent care center	$10 copayment per visit for children up to age 26 for participating providers
	$40 copayment per visit for non-participating providers
	$15 copayment per visit for children up to age 26 for non-participating providers
• Emergency care as an outpatient or inpatient at a hospital , including doctors' services	$100 copayment per visit
Not covered: Elective care or non-emergency care	*All Charges.*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office	$25 copayment per visit to primary care physician
	$35 copayment per visit to specialist
• Emergency care at an urgent care center	$40 copayment per visit for non-participating providers
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$100 copayment per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges.*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	
• Ground ambulance	$50 copayment per occurrence
• Air ambulance	$100 copayment per occurrence
Inter-Facility Transfer: • Ground Ambulance	Nothing

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	**High Option**
• Air Ambulance	$100 copayment per occurrence
Not covered: Inter-Facility Transfer Services if not preauthorized	*All Charges.*

Section 5(e) Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

- To access mental health services, simply contact the Presbyterian Health Plan Behavioral Unit at 505-923-5470 or 1-800-453-4347. The behavioral health provider is responsible for any preauthorizations.

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	$25 copayment per visit

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 copayment per visit
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing if received during the office visit or inpatient hospital admission; otherwise applicable physician visit copayment
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$100/day copayment per admission up to 5 days
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$150 copayment per visit
Not covered	**High Option**
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another*	All charges

Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically.**
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A Plan provider must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy, (except for out-of-area emergencies), or by mail. Mail order medications are available through the Mail Service Pharmacy. You may obtain the name of the Mail Service Pharmacy by calling our Customer Service Center at 505-923-5678 or 1-800-356-2219. Order forms are available from the Plans's Customer Service Center or on our website at www.phs.org.
- **We use a Preferred Drug List.** Prescription medications are prescribed by a Plan provider and dispensed in accordance with the Plan's Preferred Drug List. The Preferred Drug List is a list of generic and brand name medications that we selected to meet patient needs for quality treatment at a lower cost. You may request a copy of this Preferred Drug List by calling our Customer Service Center at 1-800-356-2219 or 505-923-5678. An on-line version of our Preferred Drug List is also available at our web site – www.phs.org (click on Health Plans, Pharmacy, Member and Commercial Group 4-Tier Formularies).
- Prescription medications prescribed by a Plan provider and obtained at a Plan pharmacy will be dispensed for up to a 30 day supply up to the maximum dosing recommended by the manufacturer. You have the option to purchase a 90-day supply of medications at a Plan Pharmacy. Under the 90-day at retail pharmacy benefit, Preferred and Non-preferred medications can be obtained from a Plan pharmacy. You will be charged three of the applicable copayments for a 90-day supply up to the manufacturer's usual maximum recommended dosing for the medication.
- Medications purchased through the mail order option will be for a 90-day supply up to the maximum dosing recommended by the manufacturer. Specialty Pharmaceuticals are not available through the mail order option.
- If you or your healthcare provider request a brand name drug in place of the generic, you pay the difference in price between the brand and generic, plus the applicable generic copayment.

These are the dispensing limitations.

Prescription refill requests through a Plan pharmacy or the mail order option will be processed at or near the expected time at which the original supply of medication would be exhausted. Requests for early refills can be made to the Plan pharmacy, who can then request approval from the Plan. Replacement prescriptions resulting from loss, theft, or destruction are not a covered benefit.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications, should call our Customer Service Center at 505-923-5678 or 1-800-356-2219.

Why use generic drugs? Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your Plan less money than a name-brand drug.

When you do have to file a claim.

If a charge is made to you for covered pharmacy benefits, you must provide proof of such charge with a copy of the pharmacy receipt with the name of the drug, quantity dispensed, and National Drug Code (NDC) number. Any charge shall be paid only upon receipt of proof satisfactory to the Plan of the occurrence, character and extent of the event and services for which claim is made.

Submit your prescription reimbursement request to:

Presbyterian Health Plan

Attention: Pharmacy

P.O. Box 27489

Albuquerque, NM87125-7489

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies on the Preferred drug list when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Tobacco Cessation medications that require a prescription by Federal law – no copayment required. • OTC Tobacco Cessation products covered if prescribed by a Plan doctor in conjunction with the Plan's Tobacco Cessation Program – no copayment required. • Insulin • Diabetic supplies, including insulin syringes, needles, blood test strips, urine test tape, and acetone test tablets. • Disposable needles and syringes for the administration of covered medications • Specialty Pharmaceuticals (Tier 4 medications obtained through the Pharmacy benefit): Specialty Pharmaceuticals are defined as high cost (greater than $600 per 30 day supply) injectable, infused, oral or inhaled drugs that generally require complex care and supervision. These medications involve unique distribution and are usually provided by a specialty pharmacy vendor. Specialty Pharmaceuticals are used to treat serious chronic, often rare conditions such as: Hepatitis, Multiple Sclerosis, rheumatoid Arthritis, Growth Disorders, Hemophelia, Immune Disorders, Osteoporosis, Immunosuppressive drugs following transplant surgery etc. Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient or to the patient by a family member or care-giver. Some Specialty Pharmaceuticals may require Benefit Certification before they can be obtained. For a complete list of Specialty Pharmaceuticals and to determine which require Benefit Certification, please see the Presbyterian Pharmacy website at:	**Retail** Tier 1 – Preferred Generic Drugs $10 copayment per 30 day supply up to the maximum dosing recommended by the manufacturer Tier 2 – Preferred Brand Drugs $40 copayment per 30 day supply up to the maximum dosing recommended by the manufacturer Tier 3 – Non-Preferred Drugs $75 copayment per 30 day supply up to the maximum dosing recommended by the manufacturer Tier 4 – Specialty Pharmaceuticals 25% of all charges up to a maximum out-of-pocket of $250 per prescription and $2,000 per Calendar Year **Mail order** Tier 1 – Preferred Generic Drugs $20 copayment per 90 day supply up to the maximum dosing recommended by the manufacturer Tier 2 – Preferred Brand Drugs $80 copayment per 90 day supply up to the maximum dosing recommended by the manufacturer Tier 3 – Non-Preferred Drugs $150 copayment per 90 day supply up to the maximum dosing recommended by the manufacturer Tier 4 – Specialty Pharmaceuticals Not available for Mail order

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
http://www.phs.org/PHS/programs/pharmacy/formulary/index.htm	**Retail** Tier 1 – Preferred Generic Drugs $10 copayment per 30 day supply up to the maximum dosing recommended by the manufacturer Tier 2 – Preferred Brand Drugs $40 copayment per 30 day supply up to the maximum dosing recommended by the manufacturer Tier 3 – Non-Preferred Drugs $75 copayment per 30 day supply up to the maximum dosing recommended by the manufacturer Tier 4 – Specialty Pharmaceuticals 25% of all charges up to a maximum out-of-pocket of $250 per prescription and $2,000 per Calendar Year **Mail order** Tier 1 – Preferred Generic Drugs $20 copayment per 90 day supply up to the maximum dosing recommended by the manufacturer Tier 2 – Preferred Brand Drugs $80 copayment per 90 day supply up to the maximum dosing recommended by the manufacturer Tier 3 – Non-Preferred Drugs $150 copayment per 90 day supply up to the maximum dosing recommended by the manufacturer Tier 4 – Specialty Pharmaceuticals Not available for Mail order
• Fertility drugs, oral or injectable, including those provided in a physician's office	50% of all charges
• Special Medical Foods are covered when prescribed by a physician for treatment for Genetic Inborn Errors of Metabolism, when used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status, when you are under the physician's ongoing care and when preauthorized by Us.	50% of all charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements that can be purchased without a prescription* • *Replacement prescriptions resulting from loss, theft, or destruction* • *Drugs from which there is a nonprescription equivalent available* • *Medical supplies such as dressings and antiseptics* • *Nonprescription medicines* • *Drugs for which prior approval has been denied or not obtained* • *Drugs and supplies related to sex transformation* • *Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products. Special Medical Foods are not covered for conditions that are not present at birth.* Note: Over-the counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit and require a written prescription by an approved provider (Pg. 32)	*All charges*

Section 5(g) Dental benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental and Vision Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no Calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Desription	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$25 copayment per visit to primary care physician $35 copayment per visit to specialist
Dental benefits (Limited) Limited dental services will be provided. Services include, but are not limited to, the following: • Oral surgery medically necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space. • Removal of infected teeth in preparation for certain surgeries or radiation therapy of the head and neck. **Temporomandibular Joint Disorders (TMJ)** The treatment of Temporomanidibular Joint disorders (TMJ) are subject to the same conditions and limitations as are applicable to treatment of any other joint in the body. Orthodontics are not covered unless the TMJ disorder is the result of an injury. (See also Oral and Maxillofacial surgery Section 5(a).	$25 copayment per visit to primary care physician $35 copayment per visit to specialist

Section 5(h) Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative benefit, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-905-3282 and talk with a registered nurse who will discuss treatment options and answer your health questions. The Nurse Advice Line is confidential. You will be asked to provide some basic information to ensure that you are part of the Presbyterian Health Plan. There is no limit to the number of calls you can make.
Services for deaf and hearing impaired	Contact our Customer Service Center at 505-923-5699 or toll-free at 1-877-298-7407
Pregnancies (Including High-Risk pregnancies)	• PRESious Beginnings is a statewide program that determines high-risk pregnancies and offers care management, literature and use of videos. Peri-Natal nurses are available for questions Monday through Friday 8:30 a.m. to 5:00 p.m. to assist with high-risk pregnancy questions. For additional information, call 505-724-6500 • Doula services are available for Members who deliver at Presbyterian Hospital. For more information, call 505-724-6500.
Presbyterian Healthcare Services	Presbyterian Health Services offers several health improvement classes to Presbyterian Health Plan members and the general public. Fees vary according to status of participant. Visit our website at www.phs.org or call our Customer Service Center at 505-923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired 505-923-5699 or toll-free 1-877-298-7407.
Vision discounts	The Access Plan available through Vision Service Plan (VSP) offers vision services at discounted rates through VSP providers. Please refer to the Presbyterian Value Added flyer for more details or visit www.vsp.com for further information.

Feature	Description
Acupuncture, Chiropractic, Massage Therapy, Meals on Wheels, Fitness Center, Vision and Hearing Hardware discounts	Discounted services are available through Benefit Source and their contracted providers. Please refer to the Presbyterian Value Added flyer or visit www.benefitsource.org for further details.
Clinical Trials	Routine patient care costs that are incurred as a result of participation in a Cancer Clinical Trial in New Mexico are Covered. **Routine patient care costs mean:** • Medical services or treatment that is a benefit under this health plan that would be Covered if the patient were receiving standard cancer treatment; or • A drug provided to a patient during a Cancer Clinical Trial if the drug has been approved by the Federal Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug. **Routine patient care costs are Covered for Members in a Cancer Clinical Trial if:** • The Cancer Clinical Trial is undertaken for the purposes of the prevention of or the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists. • The Cancer Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent. • The Cancer Clinical Trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention. • There is not a non-Investigational treatment equivalent to the Cancer Clinical Trial. • There is a reasonable expectation shown in clinical or pre-clinical data that the Cancer Clinical Trial will be at least as efficacious as any non-Investigational alternative. • There is a reasonable expectation based on clinical data that the medical treatment provided in the Cancer Clinical Trial will be at least as effective as any other medical treatment. • Pursuant to the patient informed consent, Presbyterian is not liable for damages associated with the treatment provided during any phase of a Cancer Clinical Trail. **The Clinical Trial Test must be conducted with the approval of a federal organization such as National Institutes of Health or the FDA.** • If services are not available from a Participating Provider/Practitioner, PHP will Cover services of a Non-Participating Provider/Practitioner only if the Provider/Practitioner agrees to accept PHP's normal reimbursement for similar services, and services are provided in New Mexico. • Any care related to the Clinical Trial Test that is investigational requires Benefit Certification by PHP. Those medical services that are not investigational such as lab and x-ray services would require Preauthorization as identified in this Section 3. **Exclusions:** • Any Cancer Clinical Trials provided outside of New Mexico as well as, those that do not meet the requirements indicated above. • Costs of the Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

	• Services from Non-Participating Providers/Practitioners, unless services from a Participating Provider/Practitioner are not available. Any Non-Participating services must be Preauthorized by PHP and provided for in New Mexico. The cost of a non-FDA-approved investigational drug, device or procedure. • The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Cancer Clinical Trial. • Cost associated with managing the research that is associated with the Cancer Clinical Trial. • Costs that would not be Covered if non-investigational treatments were provided. • Cost of tests that are necessary for the research of the Clinical Trial. • Costs paid or not charged for by the Cancer Clinical Trial Providers.

Section 5(i) Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsiblity of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 505-923-5678 or visit their website at www.phs.org.

For additional information and customer service call Dental Source:

Albuquerque Area: (505) 237-1501

Outside Albuquerque: 1-888-862-8659

- **Federal Dual Choice Dental Option** – The DentalSource Companion Plan is offered in conjunction with DentalSource and is available to Presbyterian Federal Health Plan Members. **Federal employees now have the choice of three dental plans being offered.** First is the comprehensive DentalSource Companion Indemnity Option, which offers federal employees the freedom to use any dentist of their choice. The second option provides an extremely affordable, comprehensive dental program through a network of dentists. The third option is an Indemnity Plan offered through Companion Life Insurance Company.

Indemnity Federal Plan (see any dentist)

DentalSource / Companion Indemnity Federal Plan is a fee for service dental plan that enables you and your family to see any licensed dentist in the world. The plan provides 100% coverage for Preventive Services, 80% coverage for Basic Services and 50% for Major Services. A waiting period applies to major services. The plan has a $100 lifetime deductible (once it is paid, it never has to be paid again) and a Calendar year maximum of $1000 per member.

Referral Plan

DentalSource Sandia Plan is a referral dental option available to Presbyterian Federal Health Plan Members. DentalSource Sandia Plan features no deductibles, no Claims Forms, no Waiting Periods, no Maximums, and no Pre-existing Condition Exclusions. This comprehensive plan provides reduced out of pocket costs for preventive and diagnostic services, fillings, crowns, and dentures, oral surgery, root canals, gum surgery, and braces for adults and children. Members select a dentist of their choice from a list of participating dentists throughout the community. A dental fee schedule lists each dental procedure with a specific fee, which is paid at the time dental services are received.

Indemnity Plan through Companion Life Insurance Company

DentalSource now provides an Indemnity Plan through Companion Life Insurance Company. This plan offers Presbyterian Federal Employees the freedom to use any dentist of their choice. The plan has a $1000 Annual Maximum and a $100 Lifetime deductible per person. Presbyterian Federal Members may only enroll during the Federal Open Enrollment Season. Only Presbyterian Federal Employees new hires may enroll after the dental open season has closed and must do so within the first 60 days of employment.

- Value Added Vision Discount

Exams – 20%

Glasses – 20% off

Contact Lens Exam (Fitting and Evaluation) – 15% off

Laser Surgery (Lasik and PRK) – Average 15% - 20% off

Presbyterian members must use a VSP provider to receive a discount. Discounts are only available through the VSP doctor who provided an eye exam within the last 12 months. To find a VSP provider near you, log on to VSP's website at www.vsp.comor call VSP's Member Services at 1-800-877-7195.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

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We do not cover the following:

- Care by non-plan providers except for authorized services or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service; or
- Travel expenses.

Section 7 Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior approval), including urgent care claims procedures). When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 505-923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407, or at our Web site at www.phs.org.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.
- For emergency or urgent care services outside the United States you are responsible for ensuring that claims are appropriately translated and that the monetary exchange, on the date of service, is clearly identified when submitting claims.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Presbyterian Health Plan
P.O. Box27489
Albuquerque, NM87125-7489

Prescription drugs

If a charge is made to you for covered pharmacy benefits, you must provide proof of such charge with a copy of the pharmacy receipt with the name of the drug, quantity dispensed, and National Drug Code (NDC) number. Any charge shall be paid only upon receipt of proof satisfactory to the Plan of the occurrence, character and extent of the event and services for which claim is made.

Submit your claims to:

Presbyterian Health Plan
Attn: Pharmacy
P.O. Box 27489
Albuquerque , NM 87125-7489

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8 The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.phs.org.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: P.O. Box 27489 Albuquerque, NM 87125-7489 ; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you , free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you and our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has the right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (505) 923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired at (505) 923-5699 or toll-free at 1-877-298-7407. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

- **When you have other health coverage**

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. We follow the NAIC guidelines regarding Coordination of Benefits.

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800/356-2219 or see our Web site at www.phs.org.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of the Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan:

You may enroll in the Presbyterian Senior Care Medicare Advantage Plan for FEHBP and also remain enrolled in the Presbyterian Health Plan's FEHBP Commercial Plan. The Presbyterian Senior Care Medicare Advantage Plan will be primary and the Presbyterian Health Plan's FEHBP Commercial plan will have coverage for prescription drugs. So, if you are enrolled in Medicare Part D, the Presbyterian Health Plan FEHBP Commercial plan will coordinate your prescription drug coverage with Medicare Part D. You must select a primary care provider from the Presbyterian Senior Care Plan, however, referrals are not required for network specialists, except for: Podiatry; Otolaryngology (Ear, Nose, and Throat); Occupational, Physical and Speech/Language Therapies. Presbyterian Senior Care and Presbyterian Health Plan's FEHBP Commercial plan will coordinate your medical benefits.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFED.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket costs.

Clinical Trials

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.

- Extra care costs – cost related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not part of the patient's routine care. (a) This plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information see page 53. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Section 10 Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 9.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 9.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, accidental injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

Experimental or investigational service

The plan evaluates any new procedures, drug therapies, treatments, devices, etc. to determine if they are Experimental/investigational in nature. This evaluation includes review of current literature published in peer review journals and appropriate information from governmental regulatory bodies, such as the FDA. We also utilize reliable evidence (consensus of opinion in the medical community) to determine if the procedure, drug therapies, treatments, devices, etc. is contraindicated for the particular indication which it has been prescribed. Please contact the plan for a more detailed explanation of this evaluation process.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Appropriate or necessary services as determined by our plan doctor in consultation with the plan, which are given to you for any covered condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness, injury, or medical condition, and are not services provided only as a convenience.

Plan allowance

Plan allowance is the amount we use to determine our payment and your Coinsurance for Covered services. Plans determine their allowances in different ways. We determine our allowance as follows: Total allowable charges for plan providers may not exceed the amount the provider service and the non-plan providers, the total allowable charges may not exceed the Plan allowance as determined by the plan for a service.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-serve claims and not Post-service claims. We will judge whether the claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Center at 505-923-5678 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 or by accessing our website at www.phs.org. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to Presbyterian Health Plan.

You You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage if for you, your spouse, and your dependent children, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB Plan, that person may not be enrolled in or covered as a family member by another FEHB Plan.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of Self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions.

These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, insulin, products, and physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit **www.FSAFEDS.com** or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program **provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

Dental Insurance

All dental plans provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a serve cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an adult day care. To quality for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY): 1-800-843-3557 or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the High Option of the Presbyterian Health Plan - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: Primary Care Physician $25 Specialist $35 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	19
Services provided by a hospital:		
• **Inpatient**	$100/day up to 5 days	39
• **Outpatient**	$150	40
Emergency benefits	$100 outpatient hospital visit	43
• **In-area**	$40 urgent care center; $100 for ER visit	43
• **Out-of-area**	$40 urgent care center; $100 for ER visit	43
Mental health and substance abuse treatment:	Regular cost sharing	45
Prescription drugs (Retail)	$10 Generic (Preferred) drugs $40 Brand (Preferred) drugs $75 non-Brand (Non-preferred) drugs Tier 4 – Specialty Pharmaceuticals 15% of charges up to a maximum out-of-pocket of $250 per prescription and $2,000 per Calendar Year	47
Dental care	Limited benefit. Applicable physician visit copayment	51
Vision care	30% of all charges (materials) Applicable physician visit copayment (eye exam for children).	26
Special features: Flexible benefits option; Services for deaf and hearing impaired, pregnancies, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, cancer clinical trials, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts		52

High Option Benefits	You pay	Page
Protection against catastrophic costs (your out-of-pocket maximum)**:**	Nothing after $2,000/Self Only or $4,000/ Family enrollment per year Some costs do not count toward this protection	15

2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.