Presbyterian Health Plan

www.phs.org

Customer Service: 800-356-2219

2027

A Health Maintenance Organization (High, Standard and Wellness Options)

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 12 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 16
- Summary of Benefits: Page 111

Serving: 5 central *counties of New Mexico*

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See section 1, page 14 for requirements.

Enrollment codes for this Plan:

High Option

- **P21 Self Only**
- **P23 Self Plus One**
- **P22 Self and Family**

Standard Option

- **PS4 Self Only**
- **PS6 Self Plus One**
- **PS5 Self and Family**

Wellness Option

- **PS1 Self Only**
- **PS3 Self Plus One**
- **PS2 Self and Family**

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-563

Important Notice from Presbyterian Health Plan About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Presbyterian Health Plan prescription drug coverage meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 your FEHB 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 your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D 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% higher than what many other people pay. You will 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 15 through December 7) 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 800-772-1213, TTY: 800-325-0778.

Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB Plan. Refer to the Part D-IRMAA section of the Medicare website https ://www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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 800-MEDICARE (1-800-633-4227), (TTY 877-486-2048).

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Introduction

This brochure describes the benefits of Presbyterian Health Plan under contract (CS 2627) between Presbyterian Health Plan and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The Presbyterian Customer Service Center can be reached at 800-356-2219 or through our website: www. phs.org/fehb. The address for Presbyterian Health Plan's administrative offices is:

Presbyterian Health Plan
9521 San Mateo, NE
Albuquerque, NM 87113

Or

P.O. Box 27489
Albuquerque, NM 87125-7489

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2027, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for plan annually. Benefit changes are effective January 1, 2027, and changes are summarized on page 15. 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 and each covered 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.
- Our brochure and other FEHB Plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Healthcare Fraud!

Fraud increases the cost of healthcare 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 phone or to people you do not know, except to your healthcare providers, authorized health benefit plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- 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 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

OR go to www. opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also 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)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a family member, 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 (TCC).
- 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.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, or through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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 or nutritional supplements you are taking.

Patient Safety Links

For information on patient safety, please visit

- www. jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB Plan will incur costs to correct the medical error.

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 preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

  Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance 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 that 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, give you other plan's brochures 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 do not 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, disability leave, pensions, etc. you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family member. Family members include your spouse, and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB Plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB Plan.

If you have a qualifying event (QLE), such as marriage, divorce, or birth of a child, outside of the Federal Benefits Open Season you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 Plus One or 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP)

Presbyterian Health Plan does not offer EGWP plans.

- **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 processed according to the 2027 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2026 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 by 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 an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 information about your coverage choices. You can also visit OPM's Website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, 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 or Tribal job, or if you are a covered child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

- **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 or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-356-2219 or visit our website at www.phs.org.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provide up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB Plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Presbyterian Health Plan holds the following accreditations: NCQA and/or the local plans and vendors that support Presbyterian Health Plan hold accreditation from NCQA. To learn more about this plan's accreditation(s), please visit the following websites: www.phs.org. We require you to see specific providers, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option, a Standard Option, or a Wellness Option.

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 copays 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 provider, hospital, or other provider will be available and/or remain under contract with us.

General features of our High, Standard, and Wellness 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 provider or by another participating provider in the network.

How we pay providers

We contract with individual providers, 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 cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Our Fee Schedule is based on the Resource Base Relative Value Scale (RBRVS). The RBRVS method was designed by providers 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 providers receive reimbursement for both evaluation and management services and procedures. The effect upon the individual provider will vary depending upon how much time they spend in office-based services as compared to procedural-based services.

Typically, providers such as primary care providers, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office-based services, and providers such as surgeons, 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 and responsibilities

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 Website www. opm.gov/healthcare-insurance/ 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
- 111 Years in existence

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www. phs.org. You can also contact us to request that we mail a copy to you.

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 711 or toll-free 800-659-8331. You may also visit our Website at www. phs.org/fehb.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www. phs.org/fehb to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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 providers 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 counties of New Mexico listed below.

- Bernalillo
- Sandoval
- Santa Fe
- Torrance
- Valencia

Please check with our Presbyterian customer service at (505) 923-5678 or 800-356-2219 or TTY for the hearing impaired at 711 to see if your specific zip code meets the service area requirements.

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 healthcare 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 covered family members 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 Provider. 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. Changes for 2027

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.

Presbyterian's service area only offers enrollment in the 5 central counties of New Mexico. Please see section 1, page 14 for requirements.

Program-wide Changes

Presbyterian Health Plan will be changing its service area to only serve the 5 central counties of New Mexico. You must live or work in the following geographic service area to enroll:

Changes to High Option:

- **Premium** - Your share of the premium rate will increase for Self Only, Self Plus One and for Self and Family. (See back cover)
- We have no benefit changes

Changes for Standard Option:

- **Premium** - Your share of the premium rate will increase for Self Only, Self Plus One and for Self and Family. (See back cover)
- We have no benefit changes

Wellness Option

- **Premium** - Your share of the premium rate will increase for Self Only, Self Plus One and for Self and Family. (See back cover)
- We have no benefit changes

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 letter (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 505-923-5678 or 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331. You may write to us at P.O. Box 27489, Albuquerque, NM 87125 You may also request replacement cards through our Website: www.phs.org/fehb.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **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 Website: www.phs.org/doctors-services/Pages/find-a-doctor.aspx. Presbyterian Health Plan's provider directory has a section that lists all participating facilities, hospitals, and pharmacies across the state.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.phs.org/fehb.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, notational origin, age, disability, religion, sex, pregnancy, or genetic information.

This plan provides Care Coordinators for complex conditions and can be reached at 800-356-2219 or through our website: www.phs.org/fehb. for assistance.

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 provider. This decision is important since your primary care provider provides or arranges for most of your health care. You must select a primary care provider from the PHP provider directory. Locations and phone 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 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331 or by accessing our website at www.phs.org/fehb. 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.

- **Primary care**

Your primary care provider can be a family practice, general practice, internal medicine, pediatrics, and OB/GYN (if applicable) acting as a primary care provider. Your primary care provider will provide most of your healthcare or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care provider will create your treatment plan. The provider may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
  - we terminate our contract with your specialist for other than cause;
  - we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - we reduce our service area and you enroll in another FEHB plan;

Contact us at (505) 923-5678, 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.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

- **Hospital care**

Your Plan primary care provider 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 800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 711 or 800-659-8331. 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 provider 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 provider has authority to refer you for most services. For certain services, however, your provider must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants

We call this review and approval process pre-authorization. Your provider 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 Use Disorder care.

Except in medical emergency you must obtain pre-authorization prior to seeing a non-Plan provider. Your Plan provider must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan provider 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 provider, your hospital, you, or your representative must call us at 800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 711 or 800-659-8331 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 provider;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the provider 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 provider 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide 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.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us toll-free at 800-356-2219. For the hearing impaired, call our TTY line at 711 or toll-free at 800-659-8331. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us toll-free at 800-356-2219. For the hearing impaired, call our TTY line at 711 or toll-free at 800-659-8331. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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, we will make a decision within 24 hours after we receive the claim.

- **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 precertification of 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 cesarean section, then your provider or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your provider or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, we will make a decision within 24 hours after we receive the claim.

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 provider 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 Use Disorder care.

Except in a medical emergency you must obtain pre-authorization prior to seeing a non-Plan provider. Your Plan provider must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan provider 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 your claim is in reference to a contraceptive, call 800-356-2219.

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 healthcare 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.

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. 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 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.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite 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 Cost for Covered Services

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

Cost-sharing

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: High option, when you see your primary care provider **for non-preventive services**. you pay a copay of $25 per office visit, and when you go see a specialist, you pay a copay of $50 per office visit. When you see your primary care provider **for preventive services**, you pay nothing for the office visit and when you go see a specialist, you pay a copay of $50 for adult and $20 for children per office visit. When you go in the hospital, you pay $175 copay per day up to 5 days per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before the plan starts paying benefits. Copayments do not count toward any deductible.

- This High Option HMO plan does not have a deductible.
- The calendar year deductible is $500 per person under the Standard Option and $2,000 under the Wellness Option plan. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500 under Standard Option and $2,000 under the Wellness Option plan. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000 under the Standard Option and $4,000 under the Wellness Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our plan, you pay 30% of the plan allowance for iatrogenic infertility preservation.

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your (deductible, copayments and coinsurance) reaches the out of pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum.

Your out-of-pocket maximum for services rendered during the 2026 calendar year is:

Self Only $6,350 or $8,150

Self Plus One $6,350 or $8,150/person

Self and Family $12,700 or $16,300

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:

- Dental services
- Vision services
- Non-covered charges

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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 more than their governing laws allow. You may be responsible for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rigths

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services, out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care - when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of New Mexico under the New Mexico Surprise Billing Protection Act (59A-57A, NMSA 1978) and the No Surprises Act.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.phs.org or contact the health plan at 800-356-2219.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP Plans. This means that when you or your provider files claims with your FEHB or FEDVIP Plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High, Standard and Wellness Options Benefits

See page 15 for how benefits changed this year. Page 107-112 is a benefits summary of the High, Standard and Wellness options. Make sure you review the benefits that are available in which you are enrolled.

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Section 5. High, Standard and Wellness Option Benefits Overview

This Plan offers a High, Standard and Wellness Option. All benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High, Standard, and Wellness Option Section 5 is divided into subsections. Please read *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 filing advice, or more information about High, Standard and Wellness Option benefits, contact us at 505-923-5678 or on our website at www. phs.org.

Each option offers unique features.

- **High Option** - The High Option does not have a deductible.
- **Standard Option** - The calendar year deductible is $500 per person under the Standard Option. Under a Self Only enrollment, the deductible is considered satisfied, and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $500 under Standard Option. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied, and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $1,000 under the Standard Option.
- **Wellness Option -** The calendar year deductible is $2,000 under the Wellness Option plan. Under a Self Only enrollment, the deductible is considered satisfied, and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $2,000 under the Wellness Option plan. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied, and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $4,000 under the Wellness.

Section 5(a). Medical Services and Supplies Provided by Providers and Other Healthcare 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 providers must provide or arrange your care.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 per Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year 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.
- The coverage and cost-sharing listed below are for services provided by providers and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay		
Diagnostic and treatment services	**High Option**	**Standard Option**	**Wellness Option**
Professional services of providers • Primary Care Provider	$25 copay per visit $0 copay 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)	$30 copay per visit, No deductible (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	First 4 visits: $20 copay, No deductible Subsequent visits: 30% coinsurance, Deductible applies
• Specialist	$50 copay per visit to specialist $20 copay per visit to specialist for children up to age 26	$50 copay per visit, No deductible (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	$50 copay, No deductible (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)

Diagnostic and treatment services - continued on next page

Benefit Description	You pay		
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
	(Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)		

Diagnostic and treatment services - continued on next page

Benefit Description	You pay		
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Applied Behavioral Analysis (ABA) Diagnosis and Treatment for all children up to age 26	$0 copay per visit	$0 copay per visit No deductible	30% coinsurance Subject to deductible
Telehealth services	**High Option**	**Standard Option**	**Wellness Option**
Telehealth (Video) visits An alternative access point for members to receive care for non-urgent medical issues such as upper respiratory infections, flu, cold, cough, and allergies. To access video visits you may visit the website at www. phs.org/ videovisits.	$0 copay per visit	$0 copay per visit No deductible	$0 copay No deductible
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**	**Wellness Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test • Pathology	$25 copay per test	$25 copay per test, No deductible	$25 copay first two (2) visits, No deductible 30% coinsurance deductible applies for visits thereafter
• X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG	$50 copay per test, No deductible No charge for Maternity Ultrasounds	$50 copay per test, No deductible No charge for Maternity Ultrasounds	$50 copay first two (2) visits, no deductible 30% coinsurance deductible applies for visits thereafter No charge for first two (2) Maternity Ultrasounds 30% coinsurance deductible applies for visits thereafter
Computed Axial Tomography (CAT) scans/ Magnetic Resonance Imaging (MRI) tests/ Positron Emission Topography (PET) scans	$150 copay per test	$100 copay per test, No deductible	30% coinsurance Deductible applies
Sleep Studies- Outpatient overnight stay without admission	$100 copay per test	$50 copay per test, No deductible	30% coinsurance Deductible applies
Sleep Studies-Outpatient overnight stay with admission	$100/day copay per admission up to 5 days	30% coinsurance per admission Deductible applies	30% coinsurance Deductible applies

Benefit Description	You pay		
Preventive care, adult	**High Option**	**Standard Option**	**Wellness Option**
Routine physical every year. **The following preventive services are covered at the time interval recommended at each of the links below:** • U.S Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force(USPSTF) website at https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https ://www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https ://www. healthcare.gov/myhealthfinder	Nothing	Nothing No deductible	Nothing No deductible
Routine mammogram	Nothing	Nothing No deductible	Nothing No deductible
Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visithttps ://www. cdc.gov/vaccines/imz-schedules/index.html	Nothing	Nothing No deductible	Nothing No deductible

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Wellness Option**
PHP covers, without cost sharing, IBT that reflects USPSTF evidence-based content for frequency and duration of services (minimum 1-2 years). This benefit is offered to members with or without anti-obesity medication. Program choices last 12 months (six months core with weekly modules, six months maintenance) and align with the National Diabetes Prevention Program (NDPP) approach for effective interventions. Components include nutrition therapy, physical activity and behavior change, group support and one-on-one coaching. Obesity Complications in Those with a BMI Less than 20: As described in the Preventive Care section on page 9, PHP covers, without cost-sharing, the full range of preventive services recommended by the United States Preventive Services Task Force (USPSTF) for children and adolescents, adults, and pregnant women. Components include nutrition therapy, physical activity and behavior change, group support and one-on-one coaching. Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight- loss therapy, counseling or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy • Family centered programs when medically identified to support obesity prevention and management by an in network provider. • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5 (f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5 (b) for surgery requirements and cost share.	Nothing	Nothing No deductible	Nothing No deductible

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Preventive Vision Exam - One exam per year Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	$0 copay when using Presbyterian Vision Plan Network Provider www. davisvision.com subject to the applicable member copayments, coinsurance, and deductible.	Not covered, you pay all charges subject to the applicable member copayments, coinsurance, and deductible.	Not covered, you pay all charges subject to the applicable member copayments, coinsurance, and deductible.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**	**Wellness Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. For preventive immunizations see guidance below. • Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) schedule and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. For the current immunization schedule, visit https ://www.cdc.gov/vaccines/imz-schedules/index.html • You may also find a complete list of U.S Preventive Services Task Force (USPSTF) A and B recommendations online at www. uspreventiveservicestaskforce.org	Nothing	Nothing No deductible	Nothing No deductible

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: · Intensive nutrition and behavioral weight-loss counseling therapy PHP covers, without cost sharing, IBT that reflects USPSTF evidence-based content for frequency and duration of services (minimum 1-2 years). This benefit is offered to members with or without anti-obesity medication. Program choices last 12 months (six months core with weekly modules, six months maintenance) and align with the National Diabetes Prevention Program (NDPP) approach for effective interventions. Components include nutrition therapy, physical activity and behavior change, group support and one-on-one coaching. Obesity Complications in Those with a BMI Less than 20: As described in the Preventive Care section on page 9, PHP covers, without cost-sharing, the full range of preventive services recommended by the United States Preventive Services Task Force (USPSTF) for children and adolescents, adults, and pregnant women. Components include nutrition therapy, physical activity and behavior change, group support and one-on-one coaching. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. • When anti-obesity medication is prescribed see Section 5(f), if applicable. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity see Section 5(b).	Nothing	Nothing No deductible	Nothing No deductible
Preventive Vision Exam - One exam per year up to age 26	$0 copay when using Presbyterian Vision Plan Network Provider www. davisvision. com	Not covered, you pay all charges	Not covered, you pay all charges

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.			
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools, camp or athletic exams or travel.	*All charges*	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**	**Wellness Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth • Maternity Ultrasounds Notes: • You do not need to precertify your vaginal delivery; see page 21 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • Presbyterian offers Doula coverage for: - Deliveries at Presbyterian Hospitals in the State of New Mexico - Post pregnancy is covered up to 6 months - Virtual care is available • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	$25 copay per visit up to a maximum of $150 per pregnancy Specialists (Perinatologist) - $50 copay per visit to specialist Delivery - Inpatient - $175/day copay per admission up to 5 days (included in inpatient hospital/ facility inpatient admission copay) No charge for Maternity Ultrasounds	$30 copay per visit up to a maximum of $300 per pregnancy - No deductible Specialists (Perinatologist) - $50 copay per visit - No deductible Delivery – Inpatient - 30% coinsurance/ $2,000 Max per admission, Deductible applies No charge for Maternity Ultrasounds	$0 for routine prenatal care or for the first postpartum care visit; $50 per office visit for all postpartum care visits thereafter 0% coinsurance Deductible applies for delivery services No charge for first two (2) Maternity Ultrasounds 30% coinsurance deductible applies for visits thereafter

Maternity care - continued on next page

Benefit Description	You pay		
Maternity care (cont.)	**High Option**	**Standard Option**	**Wellness 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 Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Surgical services are covered under Section 5(b) and Hospital services are covered under Section 5(c). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	$25 copay per visit up to a maximum of $150 per pregnancy Specialists (Perinatologist) - $50 copay per visit to specialist Delivery - Inpatient - $175/day copay per admission up to 5 days (included in inpatient hospital/ facility inpatient admission copay) No charge for Maternity Ultrasounds	$30 copay per visit up to a maximum of $300 per pregnancy - No deductible Specialists (Perinatologist) - $50 copay per visit - No deductible Delivery – Inpatient - 30% coinsurance/ $2,000 Max per admission, Deductible applies No charge for Maternity Ultrasounds	$0 for routine prenatal care or for the first postpartum care visit; $50 per office visit for all postpartum care visits thereafter 0% coinsurance Deductible applies for delivery services No charge for first two (2) Maternity Ultrasounds 30% coinsurance deductible applies for visits thereafter
Not covered: *Circumcisions performed other than during the newborn Hospital stay are only covered when medically necessary.*	*All charges*	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**	**Wellness Option**
Contraceptive counseling on an annual basis	Nothing	Nothing No deductible	Nothing No deductible
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage in Section 5(f).	Nothing	Nothing No deductible	Nothing No deductible

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. You or your doctor can ask us to make an exception (Prior Authorization) to our coverage rules. We will work with your prescriber to get additional information to support your request. Information on how to submit an exception can be found here: www. phs.org/tools-resources/member/prior-authorization. Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov.	Nothing	Nothing No deductible	Nothing No deductible
Voluntary male sterilization (See Surgical Procedures Section 5 (b)	Nothing	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**	**Wellness Option**
Please refer to Section 10 for the definition and qualification of Infertility. Diagnosis and treatment of infertility specific to: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Fertility preservation for iatrogenic infertility:	$25 copay per visit to primary care provider $50 copay per visit to specialist 6 cycles of Artificial insemination per Plan year. Prior authorization is required	$30 copay per visit to primary care provider $50 copay per visit to specialist No deductible 6 cycles of Artificial insemination per Plan year. Prior authorization is required	30% coinsurance Subject to deductible 6 cycles of Artificial insemination per Plan year. Prior authorization is required

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval; • Cryoperservation of sperm and mature oocytes; and • Cryoperservation storage costs for one year	$25 copay per visit to primary care provider $50 copay per visit to specialist 6 cycles of Artificial insemination per Plan year. Prior authorization is required	$30 copay per visit to primary care provider $50 copay per visit to specialist No deductible 6 cycles of Artificial insemination per Plan year. Prior authorization is required	30% coinsurance Subject to deductible 6 cycles of Artificial insemination per Plan year. Prior authorization is required
• Fertility drugs See Section 5(f) Prescription Drug Benefits	50% of plan allowance	50% of plan allowance	30% coinsurance Subject to deductible
• Iatrogenic Infertility Perseveration • Services include the following procedures, when provided by or under the care or supervision of a Provider: - Collection of sperm - Cryo-preservation of sperm - Ovarian stimulation, retrieval of eggs - Oocyte cryo-preservation Note: Refer to our web site www.phs.org/fehb for more information regarding coverage and exclusion criteria	30% of plan allowance	30% of plan allowance	30% of plan allowance
In vitro Fertilization (IVF)	20% coinsurance of the Plan's allowance • Up to three (3) cycles per plan year • Prior authorization is required.	20% coinsurance of the Plan's allowance, no deductible • Up to three (3) cycles per plan year • Prior authorization is required.	20% coinsurance of the Plan's allowance, no deductible • Up to three (3) cycles per plan year • Prior authorization is required.
In vitro Fertilization (IVF) Prescription Drug	20% coinsurance of the Plan's allowance • Presbyterian will cover all-inclusive prescription drugs for IVF • Up to a maximum of three (3) cycles of IVF related drugs per plan year	20% coinsurance of the Plan's allowance, no deductible • Presbyterian will cover all-inclusive prescription drugs for IVF	20% coinsurance of the Plan's allowance, no deductible • Presbyterian will cover all-inclusive prescription drugs for IVF

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
	• Injectable fertility drugs will be covered under medical benefits • Fertility drugs will be covered under the prescription drug benefit	• Up to a maximum of three (3) cycles of IVF related drugs per plan year • Injectable fertility drugs will be covered under medical benefits • Fertility drugs will be covered under the prescription drug benefit	• Up to a maximum of three (3) cycles of IVF related drugs per plan year • Injectable fertility drugs will be covered under medical benefits • Fertility drugs will be covered under the prescription drug benefit

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: • Infertility services after voluntary sterilization • Cost of donor sperm • Cost of donor egg	*All charges*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**	**Wellness Option**
• Testing and treatment • Allergy injections	$25 copay per visit to primary care provider $0 copay for children up to age 26 for participating providers $50 copay per visit to specialist $20 copay per visit to specialist for children up to age 26 Allergy injections are included in the office visit copay. If there is no office visit, allergy injections are not subject to a copay. (Waived if nursing visit only)	$30 copay per visit to primary care provider $50 copay per visit to specialist Allergy injections are included in the office visit copay. If there is no office visit, allergy injections are not subject to a copay. (Waived if nursing visit only) No deductible	30% coinsurance Deductible applies
• Allergy serum	Nothing	Nothing No deductible	30% coinsurance Deductible applies
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**	**Wellness Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 53. • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided for up to 12 sessions. • Dialysis - hemodialysis and peritoneal dialysis	$25 copay per visit to primary care provider $0 copay per visit to primary care provider for children up to age 26 $50 copayment per visit specialist 50% of plan allowance up to a maximum of $500 per prescription	$30 copay per visit to primary care provider 50% of plan allowance up to a maximum of $500 per prescription	30% coinsurance, Deductible applies Associated medications, 50% of the plan allowance up to a maximum of $500 per prescription

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Medical Drugs - All drugs and routes of administration provided or administered in an outpatient setting. • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. 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 and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 19.	$25 copay per visit to primary care provider $0 copay per visit to primary care provider for children up to age 26 $50 copayment per visit specialist 50% of plan allowance up to a maximum of $500 per prescription	$30 copay per visit to primary care provider 50% of plan allowance up to a maximum of $500 per prescription	30% coinsurance, Deductible applies Associated medications, 50% of the plan allowance up to a maximum of $500 per prescription

Benefit Description	You pay		
Physical and occupational therapies	**High Option**	**Standard Option**	**Wellness 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 • Occupational therapists Note: We only cover therapy when a provider orders the care. 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 22. Note: We only cover therapy when a provider: • Orders the care • Identifies the specific professional skills the patient requires and medical necessity for skilled services; and • Indicates the length of time the services are needed 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.	$25 copay per visit $0 copay per office visit for children up to age 26 Nothing per visit during covered inpatient admission	$30 copay per visit No deductible Nothing per visit during covered inpatient admission	First 60 visits per condition: $20 copay, Not subject to deductible Subsequent visits 30% coinsurance, Subject to deductible Nothing per visit during covered inpatient admission
Cardiac rehabilitation following qualifying event/condition 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.	$50 copay per visit $20 copay per office visit for children up to age 26	$50 copay per visit No deductible	$50 copay per visit to specialist 30% coinsurance Subject to deductible
Habilitative Therapy	$25 copay per visit $0 copay per office visit for children up to age 26 No deductible	$30 copay per visit No deductible	$20 copay per visit for the first 4 visits - No deductible Subsequent visits 30% coinsurance - Subject to deductible

Physical and occupational therapies - continued on next page

Benefit Description	You pay		
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*	*All charges*
Speech therapies	**High Option**	**Standard Option**	**Wellness 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.	$25 copay per visit $0 copay per office visit for children up to age 26 Nothing per visit during covered inpatient admission.	$25 adult copay per visit $0 child copay per visit Not subject to deductible Nothing per visit during covered inpatient admission.	First 60 visits per condition: $20 copay, Not subject to deductible Subsequent visits: 30% coinsurance, Subject to deductible Nothing per visit during covered inpatient admission.
Not covered: *Speech Therapy beyond 6 consecutive months.*	*All charges*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Wellness 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 copay per visit to primary care provider $25 copay per visit to specialist	$15 copay per visit to primary care provider $25 copay per visit to specialist No deductible	30% coinsurance Subject to deductible
• Hearing testing for children through age 26 *(See Preventive care, children)*	$0 copay per visit to primary care provider $25 copay per visit to specialist	$0 copay per visit to primary care provider $25 copay per visit to specialist No deductible	30% coinsurance Subject to deductible
• Hearing aids (for children under age 18 or 21 years of age if still attending high school). We limit coverage up to $2,200 every 36 months "per hearing impaired ear".	30% of the plan allowance	30% of the plan allowance No deductible	30% coinsurance Subject to deductible
Not covered: • *Hearing aids batteries* • *Hearing aids, except for children under age 18 or under 21 if still attending high school*	*All charges*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay		
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• *Testing and examinations for hearing aids* • *Hearing services that are not shown as covered*	*All charges*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Wellness Option**
Preventive Vision Exam - One exam per year	$0 copay When using Presbyterian Vision Plan Network Provider www. davisvision. com	Not covered You pay all charges	Not covered You pay all charges
• Eye exam to determine the need for vision correction for children through age 17 (see *Preventive care, children*) • One Eye refraction per year for children under 6 when medically necessary to aid in the diagnosis of certain eye diseases	$0 copay per visit to primary care provider $20 copay per visit to specialist	$0 copay per visit to primary care provider $20 copay per visit to specialist No deductible	30% coinsurance Subject to deductible
• 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 plan allowance	50% of plan allowance	30% coinsurance Subject to deductible
• Medically necessary service - disease or injury to the eye	$25 copay per visit to primary care provider $50 copay per visit to specialist	$30 copay per visit to primary care provider $50 copay per visit to specialist No deductible	$50 copay per visit to specialist 30% coinsurance Subject to deductible

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay		
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: • *Eyeglasses or contact lenses after age 26* • *Eye exam for Standard and Wellness Option* • *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*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**	**Wellness Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 copay per visit to primary care provider $50 copay per visit to specialist	$30 copay per visit to primary care provider $50 copay per visit to specialist No deductible	First 2 visits: $30 copay, No deductible Subsequent visits: 30% coinsurance, Deductible applies
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 (except for surgical treatment)*	*All charges*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**	**Wellness Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	30% of plan allowance	30% of plan allowance	30% coinsurance Subject to deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Wellness Option**
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 plan allowance	30% of plan allowance	30% coinsurance Subject to deductible
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* *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**	**Wellness Option**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 800-356-2219 or 505-923-5678 as soon as your Plan provider prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	30% of plan allowance	50% of plan allowance	30% coinsurance Subject to deductible

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: • *Deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.* • *Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience. Also repair and replacement of items under the manufacturer or supplier's warranty. 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*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**	**Wellness Option**
• Home healthcare ordered by a Plan provider and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing	Nothing No deductible	30% coinsurance Subject to deductible
• Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. Most Specialty Pharmaceuticals require Prior Authorization and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than $600 for a 30-day supply. • Specialty Pharmaceuticals are not available through the mail order option and are limited to a 30-day supply. Some Specialty Pharmaceuticals may have additional day supply limitations. • The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan.	50% of plan allowance up to a maximum of $500 per prescription	50% of plan allowance up to a maximum of $500 per prescription	50% of plan allowance up to a maximum of $500 per prescription

Home health services - continued on next page

Benefit Description	You pay		
Home health services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
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*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**	**Wellness Option**
Chiropractic Services - 30 visits per year if medically necessary. • Your Plan provider must determine that your treatment will result in significant improvement in your condition • 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: - 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	$30 copay per office visit - Adult • 30 visits per year if determined medically necessary $20 copay per office visit - Children up to age 26 • 20 visits per year if determined medically necessary	$30 copay per office visit • 30 visits only per year if determined medically necessary No Deductible	$30 copay per office visit • 30 visits only per year if determined medically necessary No Deductible

Chiropractic - continued on next page

Benefit Description	You pay		
Chiropractic (cont.)	**High Option**	**Standard Option**	**Wellness Option**
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*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**	**Wellness Option**
Acupuncture- 30 visits per year if determined medically necessary by a Doctor of Medicine or osteopathy, or licensed or certified acupuncture practitioner Dry Needling - by a licensed or certified practitioner • Biofeedback is only covered for treatment of Raynaud's disease or phenomenon and urinary or fecal incontinence	$30 copay per office visit - Adult • 30 visits adults only per year if determined medically necessary $20 copay per office visit - Children up to age 26 • 20 visits per year if determined medically necessary	$30 copay per office visit No deductible	$30 copay per office visit No deductible
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Wellness Option**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence • Diabetes self management	No copay for educational classes and programs. Regular plan benefits apply to medical services. No copay for tobacco cessation drugs in conjunction with Tobacco Cessation Program. Quantity limits apply maximum of two 90-day treatment regiments.	No copay for educational classes and programs. Regular plan benefits apply to medical services. No copay for tobacco cessation drugs in conjunction with Tobacco Cessation Program. Quantity limits apply maximum of two 90-day treatment regiments.	$0 copay, No deductible

Educational classes and programs - continued on next page

Benefit Description	You pay		
Educational classes and programs (cont.)	**High Option**	**Standard Option**	**Wellness Option**
		No deductible	
Diabetes self-management	$50 copay per visit to specialist $20 copay per office visit for children up to age 26	$50 copay per visit to specialist No deductible	$0 copay, No deductible
Not covered: • *Hypnotherapy* • *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 copay and benefit limitation*	*All charges*	*All charges*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Providers and Other Healthcare 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 providers must provide or arrange your care.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year 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.
- The services listed below are for the charges billed by a provider or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- If you are seen in a network facility and have services (anesthesiology, emergency departments providers, radiologists, pathologists, etc.) rendered by an out-of-network provider, you will not be responsible for any costs outside of your in-network cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Please contact us if you receive any bills from out-of-network providers related to an in-network hospital visit.
- **YOUR PROVIDER 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**	**Standard Option**	**Wellness Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine 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)	Outpatient - $300 copay per visit, No deductible (included in hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per surgery, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Deductible applies

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• Surgical treatment of severe obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over their normal weight according to current underwriting standards; eligible members must be age 18 or over. Note: Refer to our web site www. phs.org/fehb for more information regarding coverage and exclusion criteria. • Insertion of internal prosthetic devices. See 5 (a) - *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns • Voluntary sterilization (e.g., Tubal ligation, vasectomy) **Note:** For female surgical family planning procedures see Family Planning Section 5(a) **Note:** For male surgical planning procedures see Family Planning Section 5(a) **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.	Outpatient - $300 copay per visit, No deductible (included in hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per surgery, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Deductible applies
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; (see Section 5(a) Foot care)*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Reconstructive surgery	**High Option**	**Standard Option**	**Wellness 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 reasonably 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 Section 5(a) 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.	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per surgery, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
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. (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to treat gender dysphoria*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Oral and maxillofacial surgery	**High Option**	**Standard Option**	**Wellness 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.	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per surgery, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
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*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**	**Wellness Option**
These **solid organ and tissue transplants** are covered and are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas 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.	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• 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** The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic Stem Cell Transplant (HSCT) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, 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 - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Wellness Option**
- 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - 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 - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Wellness Option**
- 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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 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 transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphomas - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphomas - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MDDs) - 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 lymphomas - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyoarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Wellness Option**
- Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) *Note: We cover related medical and hospital expenses of the donor when we cover the recipient.* 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.	Outpatient - $300 copay per visit, No deductible (included in the hospital/facility outpatient copay) Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies Inpatient - 30% coinsurance/$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Anesthesia	**High Option**	**Standard Option**	**Wellness Option**
Professional services provided in - • Hospital (inpatient)	Inpatient - $175/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	30% coinsurance/ $2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
Professional services provided in - • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$25 copay per visit to primary care provider $0 copay per visit to primary care provider for children up to age 26 $50 copay per visit to specialist $20 copay per office visit to specialist for children up to age 26 Outpatient - $300 copay per visit, deductible does not apply (included in the hospital/facility outpatient copay)	$30 copay per visit to primary care provider, No deductible $50 copay per visit to specialist, No deductible Outpatient - 30% coinsurance/$2,000 Max per surgery, Deductible applies	30% coinsurance Subject to deductible

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 providers must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for the **High Option** plan.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment) for the **Standard Option** plan.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 per Self and Family enrollment) for the **Wellness Option** plan.
- 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.
- If you are seen in a network facility and have services (anesthesiology, emergency departments providers, radiologists, pathologists, etc.) rendered by an out-of-network provider, you will not be responsible for any costs outside of your in-network cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Please contact us if you receive any bills from out-of-network providers related to an in-network hospital visit.
- 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., providers, etc.) are in Sections 5(a) or (b).

Benefit Description	You pay		
Inpatient hospital	**High Option**	**Standard Option**	**Wellness 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. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced	$175/day copay per admission up to 5 days	30% coinsurance/ $2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• 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.	$175/day copay per admission up to 5 days	30% coinsurance/ $2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All charges*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**	**Wellness Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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 Intensive outpatient treatment is equal to 60 consecutive days and 60 consecutive equals one admission, confinement or episode of care. One copay will apply per 60 days or episode of care. 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 copay per visit	30% coinsurance/ $2,000 Max per surgery Deductible applies	30% coinsurance Subject to deductible

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay		
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**	**Wellness 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 provider recommends	$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	30% coinsurance Deductible applies	30% coinsurance Subject to deductible
Not covered: Custodial care or domiciliary care	*All charges*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**	**Wellness Option**
The following services are covered for in-patient and in-home hospice benefits • Inpatient hospice care • Provider visits by Plan hospice providers • Home health care by approved home health care personnel • Physical therapy • Medical supplies • Drugs and medication for the terminally ill patient • 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 Notes: - Benefits are provided for in a Plan hospice or facility approved by the Plan provider 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 provider 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.	$175/day copay per up to 5 days per admission (included in hospital/facility inpatient admission copay) No charge In-home	30% coinsurance Deductible applies	30% coinsurance Subject to deductible

Hospice care - continued on next page

Benefit Description	You pay		
Hospice care (cont.)	**High Option**	**Standard Option**	**Wellness Option**
If you require an extension of the hospice benefit period, the hospice must provide a new treatment plan and the Plan provider must recertify your medical condition to us. No more than one additional hospice benefit period will be preauthorized by us.	$175/day copay per up to 5 days per admission (included in hospital/facility inpatient admission copay) No charge In-home	30% coinsurance Deductible applies	30% coinsurance Subject to deductible
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*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Wellness Option**
Local professional ambulance service when medically appropriate Ground Ambulance Air ambulance	$50 copay per occurrence $50 copay per occurrence $100 copay per occurrence	$50 copay per occurrence $50 copay per occurrence $100 copay per occurrence	30% coinsurance, Subject to deductible 30% coinsurance, Subject to deductible 30% coinsurance, Subject to deductible

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 for the **High Option** plan.
- The calendar year deductible is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- If you are seen in a network facility and have services (anesthesiology, emergency departments providers, radiologists, pathologists, etc.) rendered by an out-of-network provider, you will not be responsible for any costs outside of your in-network cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Please contact us if you receive any bills from out-of-network providers related to an in-network hospital visit.
- 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 may 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**	**Standard Option**	**Wellness Option**
• Emergency care at a doctor's office	$25 copay per visit to primary care provider $0 copay per visit to primary care provider for children up to age 26 $50 copay per visit to specialist $20 copay per visit to specialist for children up to age 26	$30 copay per visit to primary care provider $50 copay per visit to specialist, No deductible $250 copay per visit, No deductible	$300 copay for the first 2 visits, No deductible Subsequent visits: 30% coinsurance, Subject to deductible
• Emergency care at an urgent care center	$40 copay per visit	$40 copay per visit No deductible	$40 copay per visit No deductible
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$200 copay per visit If a member is admitted to the hospital, the copay will be waived	$250 copay per visit , No deductible If admitted to a hospital, then deductible and coinsurance will apply	$300 per visit for the first 2 visits, No deductible 30% coinsurance, thereafter, Subject to deductible
Not covered: Elective care or non-emergency care	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Emergency outside our service area	**High Option**	**Standard Option**	**Wellness Option**
• Emergency care at a doctor's office	$25 copay per visit to primary care provider $0 copay per visit to primary care providerfor children up to age 26 $50 copay per visit to specialist $20 copay per visit to specialist for children up to age 26	$30 copay per visit to primary care provider $50 copay per visit to specialist No deductible	30% coinsurance, Subject to deductible
• Emergency care at an urgent care center	$40 copay per visit $20 copay per visit for children up to age 26	$40 copay per visit No deductible	$40 copay per visit No deductible
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$200 copay per visit If a member is admitted to the hospital, the copay will be waived	$250 copay per visit, No deductible If admitted to a hospital, then deductible and coinsurance will apply	$300 per visit for the first 2 visits, No deductible applies 30% coinsurance, thereafter, Subject to deductible
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*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Wellness Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$50 copay per occurrence	$50 copay per occurrence	30% coinsurance, Subject to deductible
• Ground ambulance	$50 copay per occurrence	$50 copay per occurrence, No deductible	30% coinsurance, Subject to deductible
• Air ambulance	$100 copay per occurrence	$100 copay per occurrence, No deductible	30% coinsurance, Subject to deductible
Inter-Facility Transfer: • Ground Ambulance	Nothing	Nothing No deductible	30% coinsurance, Subject to deductible
• Air Ambulance	$100 copay per occurrence	$100 copay per occurrence, No deductible	30% coinsurance, Subject to deductible

Ambulance - continued on next page

Benefit Description	You pay		
Ambulance (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: Inter-Facility Transfer Services if not preauthorized	*All charges*	*All charges*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

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 have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is $500 per person ($1,000 per Self Plus One enrollment, or $1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year 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.
- 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**	**Standard Option**	**Wellness Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are not 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) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	$25 copay per visit $0 copay per office visit for children up to age 26	$30 copay per visit No deductible	First 4 visits: $20 copay, Not subject to deductible Subsequent visits 30% coinsurance, Subject to the deductible

Professional services - continued on next page

Benefit Description	You pay		
Professional services (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 copay per visit $0 copay per office visit for children up to age 26	$30 copay per visit No deductible	First 4 visits: $20 copay, Not subject to deductible Subsequent visits 30% coinsurance, Subject to the deductible
Applied Behavioral Analysis (ABA) Diagnosis and treatment for all children up to age 26	$0 copay per visit	$0 copay per visit No deductible	30% coinsurance Subject to deductible
Diagnostics	**High Option**	**Standard Option**	**Wellness Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment 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 provider visit copay	Nothing if received during the office visit or inpatient hospital admission; otherwise applicable provider visit copay No deductible	30% coinsurance Subject to deductible
Inpatient hospital or other covered facility	**High Option**	**Standard Option**	**Wellness 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	$175/day copay per admission up to 5 days	30% coinsurance/ $2,000 Max per admission, Deductible applies	30% coinsurance, Subject to deductible
Outpatient hospital or other covered facility	**High Option**	**Standard Option**	**Wellness 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 center, full-day hospitalization, or facility-based intensive outpatient treatment. Intensive outpatient treatment is equal to 60 consecutive days and 60 consecutive equals one admission, confinement or episode of care. One copay will apply per 60 days or episode of care.	$300 copay per outpatient visit	30% coinsurance/ $2,000 Max per event, Deductible applies	30% coinsurance Subject to deductible

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.
- **Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.**
- Federal or state laws may prevent the pharmacy from accepting unused drugs.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 for Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year 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.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals**, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medications.
- **Where you can obtain them.** We strongly encourage members to us participating providers to assure the highest quality and lowest cost. Use of a non-participating provider may result in additional charges to the member that are not covered under the plan. Requests for benefits performed by a non-participating provider may be denied if there is a participating provider in the network who can provide the same or similar benefit.

Prescription Drugs/Medications

Prescription Drug/Medications Benefit (Outpatient)

Outpatient Prescription Drugs are a Covered Benefit when prescribed by your Provider. Refer to your Formulary for information on approved Prescription Drugs. For a complete list of these drugs, please see the PHP Commercial Large Group formulary list at www.phs.org/fehb (Click on Insurance Plans, Employer offered, Federal Employees, Mail Services).

You have the option to purchase up to a 90-day supply of Prescription Drugs/Medications at an In-Network Retail or Mail order pharmacy. Under the 90-day at Retail Pharmacy benefit, Preferred Generic, Preferred Brand and Non-Preferred Drugs can be obtained from an In-network Pharmacy. Formulary medications maybe limited to 30-day supplies for Non-Extended Day Supply (NEDS) and Schedule II controlled substances. If you choose the 90-days at retail option, you will be charged one Copayment per 30-day supply up to a maximum of a 90-day supply.

For more information contact our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, Monday through Friday from 7 a.m. to 6 p.m. Hearing impaired users may call our **TTY** line at **711**. You may also email us at askpharmacy@phs.org.

What is a Formulary?

A drug Formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health.

The primary purpose of the Formulary is to encourage the use of safe, effective and most affordable medications. Presbyterian Health Plan administers a closed Formulary, which means that non-formulary drugs are not routinely reimbursed by the plan. Medical exceptions policies provide access to non-formulary medication when Medical necessity is established.

The medications listed on the Formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. For the most up-to-date formulary drug information visit **www.phs.org/fehb**. Presbyterian will provide material that contains in a clear, conspicuous and readily understandable form, a full and fair disclosure of the plan's benefits, **limitations, exclusions**, conditions of eligibility and prior authorization requirements, within a reasonable time after enrollment and at subsequent periodic times as appropriate.

Can the Formulary change during the year?

The Formulary can change throughout the year. Some reasons why it can change include:

- New drugs are approved.
- Existing drugs are removed from the market.
- Prescription drugs are removed from the market.
- Prescription drugs may become available over the counter (without a prescription).
- Brand-name drugs lose patent protection and generic versions become available.
- Changes based on new clinical guidelines.

If we remove drugs from our Formulary, add quantity limits, prior authorization, and/or step therapy restrictions on a drug; or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective.

How is the Formulary drug List Developed?

The medications and related products listed on the Formulary are determined by a Pharmacy and Therapeutics (P & T) Committee or an equivalent entity. The Presbyterian Health Plan P & T Committee is made up of primary care and specialty physicians, clinical pharmacists and other professionals in the health care field.

The P & T Committee reviews and updates the Formulary list each quarter (four times per year). Medications chosen for the Formulary are selected based on their safety, effectiveness and overall value. A medication may not be added to the Formulary if current drugs on the Formulary are equally safe and effective and are less costly. Utilization management strategies such as quantity limits, step therapy and prior authorization criteria are reviewed and approved by the P & T Committee.

Medication coverage criteria is updated and reviewed to reflect current standards of practice. The overall goal of the P & T Committee is to provide a Formulary that gives members access to safe, appropriate and cost-effective medications that will produce the desired goals of therapy at the most reasonable cost to the member and health care system.

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Health Care Service is Medically Necessary, a Covered Benefit, and if it is being delivered in the most appropriate health care setting. Our Medical Director or other clinical professional will review the requested Health Care Service and, if it meets our requirements for Coverage and Medical Necessity, it is Authorized (approved) before those services are provided.

The Prior Authorization process and requirements are regularly reviewed and updated based on various factors including evidence-based practice guidelines, medical trends, Practitioner/Provider participation, state and federal regulations, and our policies and procedures.

- Continuation of therapy using any drug is dependent upon its demonstrable efficacy
- Note that the prior use of free prescription medication (i.e. Samples, free goods, etc.) will not be considered in the evaluation of a member's eligibility for medication coverage

Prescribed drugs will be considered for coverage under the pharmacy benefit when all of the following are met:

- The medication is being prescribed for an FDA approved indication OR the patient has a diagnosis which is considered medically acceptable in the approved compendia* or a peer reviewed medical journal
- The patient does not have any contraindications or significant safety concerns with using the prescribed drug

If the patient does not meet the above criteria, the prescribed use is considered Experimental or Investigational for Conditions not listed in this section of Evidence of Coverage.

The approved compendia includes:

- American Hospital Formulary Service (AHFS) Compendium
- IBM Micromedex Compendium
- Elsevier Gold Standard's Clinical Pharmacology Compendium
- National Comprehensive Cancer Network Drugs and Biologics Compendium

What is Step Therapy?

Step Therapy promotes the appropriate use of equally effective but lower-cost Formulary drugs first. With this program, prior use of one or more "prerequisite" drugs is required before a step-therapy medication will be covered. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step-therapy drugs.

What are Quantity Limits?

Formulary drugs may also limit coverage of quantities for certain drugs. These limits help your doctor and pharmacist check that the medications are used appropriately and promote patient safety. Presbyterian uses medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. Quantity limits include the following:

- **Maximum Daily Dose limits** quantities to a maximum number of dosage units (i.e. tablets, capsules, milliliters, milligrams, doses, etc.) in a single day. Limits are based on daily dosages shown to be safe and effective, and that are approved by the Food and Drug Administration (FDA).
- **Quantity Limits over time limits** quantities to number of units (i.e. tablets, capsules, milliliters, milligrams, doses, etc.) in a defined period of time.

Drug Utilization Review and Drug use evaluation programs

DUR is a review of patient data which is done to evaluate the effectiveness, safety and appropriateness of medication use. These Drug Utilization Reviews occur during claim adjudication and determines whether it is likely to cause harm based on interaction with other drugs or based on the member's age, sex, allergies or other drugs on the member's pharmacy profile. The DUR reviews often alert clinicians about prescribing and drug regimen problems and about patients who may be inappropriately taking medications that can produce an undesirable reaction or create other medical complications.

Prescription Drug Refill Dispensing Limits

Refills of a prescription drug will not be covered until the member is reasonably due for a refill as calculated based upon the prescription drug being taken at the prescribed dosage and appropriate intervals and when the number of days supply the member has remaining on hand does not exceed the dispensing limits.

Generic Drugs

The Health Insurance Exchange Metal Level Formulary covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient and may be substituted for the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Brand Name drugs when a generic Equivalent is Available

A generic equivalent will be dispensed if available. If your prescriber requests to dispense a brand-name drug when a generic equivalent is available, the request will require a Medical Exception.

If Medical necessity is established the non-preferred drug copay plus the difference between the brand-name and the generic drug will apply. Otherwise, brand-name drugs dispensed when a generic equivalent is available are not covered and will not count towards the deductible or annual out-of-pocket maximums.

Affordable Care Act (ACA)

We will provide Coverage for preventive medications and products as defined by the Affordable Care Act (ACA), if you receive these services from our In-network Practitioners/Providers, without Cost Sharing regardless of sex assigned at birth, sex identity, or sex of the individual.

Preventive medications are used for the management and prevention of complications from conditions such as high blood pressure, high cholesterol, diabetes, asthma, osteoporosis, heart attack and stroke.

For preventive medications (including over-the-counter medications) or products to be Covered, a pharmacy claim will need to be submitted. Present your ID card to the dispensing pharmacy for processing and billing information. Visit the Formulary listing at **www.phs.org/fehb** (Click on Insurance Plans, Employer offered, Federal Employees, Mail Services). Preventive medications will be listed as $0 Copay per PPACA.

Behavioral Health Drugs at zero cost share

Formulary prescription drugs used for the treatment of mental illness, behavioral health, or substance abuse disorders maybe covered at no cost share. Coverage at no cost share is subject to applicable benefit plans. Refer to the formulary listing at **http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf** for additional coverage details.

Daily Cost Share

Daily cost share reduces the patient pay for the prescription that is less than the standard defined day supply. Exclusions may include drug products for acute therapy, unbreakable packages and controlled substances.

Insulin for Diabetes Cost Sharing Cap

The copay amount for a preferred formulary prescription insulin or a medically necessary alternative will be covered at an amount not to exceed a total of twenty-five dollars ($25.00)* per thirty-day supply. *Copays are subject to deductible first.

Medication Synchronization

Medication Synchronization allows Members to refill all of their Prescriptions on the same day, eliminating the need for multiple trips to the Pharmacy each month. Prescriptions are filled for less than the normal prescribed day supply in order to align the refill date across multiple prescriptions, allowing all refills on the same day and time period.

Non-Extended Day Supply

Presbyterian has established protocols under the guidance of National Committee for Quality Assurance (NCQA) in an effort to ensure patients' safety for identified high-risk medications. Pursuant to this guidance, Presbyterian has limited the maximum allowed day supply down to 30 days at a time for medications that fall into this high-risk category. These drugs are found in the Commercial 4 Tier formulary as Non-Extended Day Supplies.

Orally Administered Anti-Cancer Medications

This Plan provides coverage for orally administered anti-cancer medication used to slow or kill the growth of cancerous cells. Coverage of these medications are subject to the same Prior Authorization requirements as intravenously administered injected cancer medications covered by the Plan. Orally administered medications cannot cost more than an intravenously injected equivalent. Intravenously injected medications cannot cost more than orally administered medications.

Self-Administered Specialty Pharmaceuticals

Self-Administered Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or caregiver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life-threatening conditions. Most Specialty Pharmaceuticals require **Prior Authorization** and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high costs, typically greater than $600 for up to a 30-day supply.

Specialty Pharmaceuticals are not available through the retail or mail order option and are limited to a **30-day** supply. Certain Specialty Pharmaceuticals may have additional day supply limitations.

For a complete list of these drugs, please see the Specialty Pharmaceutical listing at PHP Commercial Large Group formulary list at **www.phs.org/fehb**

Office Administered Specialty Pharmaceuticals (Medical Drug)

A Medical Drug is any drug administered by a Health Care Professional and is typically given in the member's home, physician office, freestanding (ambulatory) infusion suite, or outpatient facility. Medical Drugs may require a Prior Authorization and some must be obtained through the specialty network.

These drugs may be subject to a separate Copayment/Coinsurance to a maximum as outlined in your *Summary of Benefits and Coverage.* For a complete list of Medical Drugs to determine which require Prior Authorization please see the Presbyterian Pharmacy website at **http://docs.phs.org/idc/groups/public/%40phs/%40php/documents/phscontent/pel_00052739.pdf.**

What if my Drug is not Covered

You or your doctor can ask us to make an exception (prior authorization) to our coverage rules. We will work with your prescriber to get additional information to support your request. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

Mail Order Pharmacy

You have a choice of obtaining certain Prescription Drugs/Medications directly from a Pharmacy or by ordering them through the mail. Under the mail order pharmacy benefit, Preferred and non-Preferred medications can be obtained through the Mail Order Service Pharmacy. You may obtain more information on the Mail-Order Pharmacy by calling our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219,** Monday through Friday from 7 a.m. to 6 p.m. TTY users may call 711.

Certain drugs may not be purchased by mail order, such as Self-Administered Specialty Pharmaceuticals.

Member Reimbursement

If a medical Emergency occurs outside of our Service Area and you use an In-network Pharmacy, you will be responsible for payment of the appropriate Copayment. We have a large, comprehensive pharmacy network; however, if you go to an Out-of-network Pharmacy, and they are unable to process the claim at point of service you may pay for the prescription and may request Presbyterian Health Plan to reimburse you. A Pharmacy Specialist will review and process your request for reimbursement based on the negotiated rate between Presbyterian Health Plan and the dispensing pharmacy minus any copay or coinsurance that may apply. Members will not be liable to a provider for any sums owed to the provider by Presbyterian.

The Pharmacy Specialist needs the following information to determine reimbursement amounts. Please submit a Member Reimbursement Form and attach the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) along with the following information:

- Patient Name
- Patient's Date of Birth
- Name of the drug
- Quantity dispensed
- NDC (National Drug Code
- Fill Date
- Name of Prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of Payment

Member Reimbursement forms are available by calling our Presbyterian Customer Service Center at **(505) 923-5678** or **1-800-356-2219**, Monday through Friday from 7 a.m. to 6 p.m. **TTY** users may call 711. Please follow the mailing instructions on the Member Reimbursement Form.

A Pharmacy Services Call Center is available 24 hours a day to providers, pharmacies and members to address pharmacy benefit questions. Please contact PCSC at **1-800-356-2219** or email **askpharmacy@phs.org.**

Benefit Description	You pay		
Tobacco cessation	**High Option**	**Standard Option**	**Wellness Option**
Tobacco and nicotine cessation medications that require a prescription by Federal Law. Quantity limits apply maximum of two 90-day regimens.	$0 copay	$0 copay	$0 copay
Over-the-counter (OTC) Tobacco and Nicotine Cessation Products covered if prescribed by a Plan doctor in conjunction with the Plan's Tobacco and Nicotine Cessation Program. Quantity limits apply maximum of two 90-day regimens.	$0 copay	$0 copay	$0 copay
Covered medications and supplies	**High Option**	**Standard Option**	**Wellness Option**
We cover the following medications and supplies on the Preferred drug list when prescribed by a Plan provider and obtained from a network pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a provider's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Medications prescribed to treat obesity - Your health plan covers FDA-approved medications used to help with weight loss. Coverage includes at least on GLP=1 weight loss medication and at least two oral weight loss medication options. Refer to your formulary for a list of covered medications.	**Retail** **Tier 0 - Maintenance Medication category to include medications and supplies used to treat diabetes, opioid overdose, and asthma.** $0 copay per 30 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. **Tier 1 - Preferred Generic Drugs** $10 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 2 - Preferred Brand Drugs** $100 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage	**Retail** **Tier 0 - Maintenance Medication category to include medications and supplies used to treat diabetes, opioid overdose, and asthma.** $0 copay per 30 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. **Tier 1 - Preferred Generic Drugs** $10 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 2 - Preferred Brand Drugs** $100 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage	**Retail** **Tier 0 - Maintenance Medication category to include medications and supplies used to treat diabetes, opioid overdose, and asthma.** $0 copay per 30 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. **Tier 1 - Preferred Generic Drugs** $10 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 2 - Preferred Brand Drugs** $100 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
	Tier 3 - Non-Preferred Drugs $125 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 4 - Specialty Pharmaceuticals** 50% of plan allowance up to a maximum out-of-pocket of $500 per prescription **Mail order** **Tier 0 - Maintenance Medication (for certain chronic conditions). For more information, see Maintenance Medications note on page 79.** 2 copays per 90 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. **Tier 1 - Preferred Generic Drugs** $20 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 2 - Preferred Brand Drugs**	**Tier 3 - Non-Preferred Drugs** $125 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 4 - Specialty Pharmaceuticals** 50% of plan allowance up to a maximum out-of-pocket of $500 per prescription **Mail order** **Tier 0 - Maintenance Medication (for certain chronic conditions). For more information, see Maintenance Medications note on page 79.** 2 copays per 90 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. **Tier 1 - Preferred Generic Drugs** $20 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 2 - Preferred Brand Drugs**	**Tier 3 - Non-Preferred Drugs** $125 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 4 - Specialty Pharmaceuticals** 50% of plan allowance up to a maximum out-of-pocket of $500 per prescription **Mail order** **Tier 0 - Maintenance Medication (for certain chronic conditions). For more information, see Maintenance Medications note on page 79.** 2 copays per 90 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. **Tier 1 - Preferred Generic Drugs** $20 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 2 - Preferred Brand Drugs**

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
	$140 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 3 - Non-Preferred Drugs** $200 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 4 - Specialty Pharmaceuticals** Not available for Mail order **Note:** If there is no generic equivalent available, you will still have to pay the brand name copay.	$140 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 3 - Non-Preferred Drugs** $200 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 4 - Specialty Pharmaceuticals** Not available for Mail order **Note:** If there is no generic equivalent available, you will still have to pay the brand name copay.	$140 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 3 - Non-Preferred Drugs** $200 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage **Tier 4 - Specialty Pharmaceuticals** Not available for Mail order **Note:** If there is no generic equivalent available, you will still have to pay the brand name copay.
Note: **Maintenance Medications** are used for the management and prevention of complications from conditions such as high blood pressure, high cholesterol, diabetes, opioid overdose and asthma. For a full list of Maintenance Medications, please visit www. phs.org/fehb. **Specialty Pharmaceuticals** are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. Most Specialty Pharmaceuticals require Prior Authorization and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than $600 for a 30-day supply.	See note	See note	See note

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Some specialty medications may qualify for third-party copay assistance is used, the Member shall not receive credit toward their maximum out-of-pocket or deductible for any copay or coinsurance amounts that are applied to a manufacturer coupon or rebate. **Specialty Pharmaceuticals** are not available through the mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill, up to a 14-day supply to ensure patients can tolerate the new medication. **The medications listed** on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. For a complete list of Specialty Pharmaceuticals and to determine which require Prior Authorization, please see the Presbyterian Pharmacy website at: www. phs.org/fehb (Prescription Drug Benefit).	See note	See note	See note
• Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. ***Expedited Pharmacy PA Requests:*** *When a member or their provider believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in jeopardy, a PA can be expedited. These requests are processed within* ***24 hours*** *after the request is received.* Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy.	$0 copay	$0 copay	$0 copay

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Once we have been contacted with exception request information sufficient for us to make a determination, you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products and exceptions please see the Presbyterian Pharmacy website at www.phs.org/fehb. An emergency contraceptive is covered over-the-counter (OTC) at no cost if prescribed by a provider and purchased at a network pharmacy. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. **Note:** For additional Family Planning benefits see Section 5(a)	$0 copay	$0 copay	$0 copay
• Oral fertility drugs	50% of plan allowance	50% of plan allowance	50% of plan allowance
• Special Medical Foods are covered when prescribed by a provider 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 provider's ongoing care and when preauthorized by us.	30% of plan allowance	30% of plan allowance	30% of plan allowance
• Drugs to treat Obesity GLP-1 (Glucagon like Peptide - 1 Receptor Agonist). Prior Authorization is required	50% of plan allowance	50% of plan allowance	50% of plan allowance
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a) *Not covered* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance*	$0	$0	$0

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications unless specifically indicated elsewhere* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria*	$0	$0	$0
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription. Prescription and over-the counter opioid rescue agents are covered under this plan with no cost sharing. For more information, consult the FDA guidance at: FDA Approves First Over-the-Counter Naloxone Nasal Spray | FDA in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	See benefit description	See benefit description	See benefit description
Preventive medications	**High Option**	**Standard Option**	**Wellness Option**
Preventive medications to promote better health as recommended by Affordable Care Act (ACA). The following drugs and supplements are covered without cost-share, even if over-the-counter are prescribed by a healthcare professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 • Anti-cholesterol agents "statins"	Nothing	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• Bowel preparations for members age 50 years or older. • Naloxone injectable with nasal atomizer. Preventive Medication with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dosage Aspirin for certain patients. For current recommendation go to www.uspreventiveservicesasforce.org/BrowseRec/Index/browse-recommendations. Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	Nothing	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Wellness Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-network pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit, even if a provider prescribes or administers them* • *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 medications* • *Drugs for which prior approval has been denied or not obtained* • *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.* • *Bulk powders* • *Drugs that have not been approved by the FDA.* • *Discount cards or Prescription Drug Savings cards to not apply to Deductible or Out-of-pocket maximums.* • *Herbal or alternative medicine and holistic supplements.* • *Vaccinations, drugs and immunizations for the primary intent of medical research or Non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance or functional capacity examinations related to employment.* • *Immunizations for the purpose of foreign travel, flight and or passports.*	All Charges	All Charges	All Charges

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	**High Option**	**Standard Option**	**Wellness Option**
• *Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including "all-natural" pills, creams, lotions and gels.* • *Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective LTE drugs are Not Covered.* • *Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are Not Covered.* • *Infant formula*	All Charges	All Charges	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 for the **High Option** plan.
- The calendar year deductible is: $500 per person ($1,000 per Self Plus One enrollment, or $1,000 for Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: $2,000 per person ($4,000 per Self Plus One enrollment, or $4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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**	**Standard Option**	**Wellness 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 copay per visit to primary care provider $50 copay per visit to specialist	$30 copay per visit to primary care provider $50 copay per visit to specialist	$50 copay per visit to specialist 30% coinsurance Subject to deductible
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)**	$25 copay per visit to primary care provider $50 copay per visit to specialist	$30 copay per visit to primary care provider $50 copay per visit to specialist	$50 copay per visit to specialist 30% coinsurance Subject to deductible

Accidental injury benefit - continued on next page

Benefit Desription	You Pay		
Accidental injury benefit (cont.)	**High Option**	**Standard Option**	**Wellness Option**
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 copay per visit to primary care provider $50 copay per visit to specialist	$30 copay per visit to primary care provider $50 copay per visit to specialist	$50 copay per visit to specialist 30% coinsurance Subject to deductible

Section 5(h). Wellness and Other 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, 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 except as expressly provided in the agreement, 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 505-923-5570 or toll-free at 866-221-9679 and talk with a registered nurse who will discuss treatment options and answer your health questions. For the hearing impaired, call our TTY line at 711 or 800-659-8331. The PresRN 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 711 or toll-free at 800-659-8331.
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/fehb or call our Customer Service Center at 505-923-5678 or toll-free at 800-356-2219 or for the hearing impaired 505-923-5699 or toll-free 877-298-7407.
Preventive Vision Exam and Discounts	One preventive vision exam per year for adults and children and no charge on the High Option only. Discounts also available. Please visit Presbyterian Vision administered by Versant Health under the Davis Vision Network at www.davisvision.com for further information.
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 Trial. **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.
Video Visits	Video Visits is an alternative access point for members to receive care for non-urgent medical issues such as upper respiratory infections, flu, cold, cough, and allergies. For more information, please see page 31.
Pharmacy Cost Calculator	Members may utilize the Pharmacy Cost Calculator to look up prescriptions, determine coverage, copays, and locate participating pharmacies. This tool can be accessed at www.phs.org/fehb.

Section 5(i). Point of Service Benefits

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 responsibility 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/fehb.

BenefitSource, Inc. and Presbyterian Health Plan have teamed up to provide three dental plan options and three vision plan options for Federal employees and their dependents.

- **Option 1: Sandia Plan**

The Sandia Plan is the most economic dental plan option. Members obtain dental services from more than 1,000 participating dentists statewide. Members enjoy guaranteed low, pre-set fees on almost all types of dental work. Savings from 20%-60% are available for most basic and major dental services. Plan discounts are designed to encourage proper dental care by promoting early detection and regular dental health maintenance. Visit our website www. benefitsource. org for a complete schedule of dental benefits and the most current list of participating Sandia Plan dental providers.

- **Option 2: Dental**

This plan is a comprehensive PPO dental Indemnity plan with the freedom of choice to see any licensed dentist. When using PPO Dental Plan providers, members have lower out-of-pocket costs and no balance billing for dental services. There is no deductible for Class I; preventive & diagnostic services and a $50 annual deductible per person, with a maximum of $150 per family for Class II and Class III services. Payment is based upon maximum allowable charge of in-network providers. Visit our website www. benefitsource.org for a complete benefit schedule and the most current list of participating PPO dental providers.

- **Federal Employee Vision Benefits**

Your medical plan is providing a No Cost Eye Exam with Vision Service Plan (VSP). Please review your Presbyterian Federal Booklet for complete information.

For members who wish to enhance their vision coverage to include materials (eye glasses and contact lenses), BenefitSource will offer a separate Buy Up option. The Buy Up options lists a choice from a large network that includes private eye care providers and retail optical centers. Members will have an opportunity to purchase a material only Buy Up plan from BenefitSource directly. Visit our website, www. benefitsource.org for a complete list of vision benefits and participating vision offices.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not 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 provider determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-Plan providers except for authorized services or emergencies (see *Emergency services/accidents*);
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services);
- 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, diagnostic genetic testing, 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 you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services or supplies we are prohibited from covering under the Federal Law.
- Travel expenses, except for limited travel benefit for organ/tissue transplants cited in 5(b).
- Any benefits or services required solely for your employment are not covered by this plan.

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 provider, 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, coinsurance, or deductible.

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 HIPAA compliant electronic claims for you. Provider must file on the form CMS-1500, Health Insurance Claim Form. In cases where a paper claim must be used, the facility will file on the UB-04 form. For claims and assistance, contact us at 505-923-5678 or toll-free at 800-356-2219, or at our website at www.phs.org/fehb.

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 provider 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. Box 27489
Albuquerque, NM 87125-7489

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. Once we pay benefits, there is a one year limitation on the re-issuance of uncashed checks.
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, a healthcare professional with knowledge of your medical condition will be permitted 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.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance) and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes
Records	Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Overseas claims	Presbyterian only covers emergency services from overseas. If you need to submit for reimbursement, send in proof of payment including check, credit card statement or receipt showing services were paid in full to the Member Services Department.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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. To make your request, please contact our Customer Service Center by writing to Presbyterian Health Plan, P.O. Box 27489, Albuquerque, NM 87125-7489 or calling 800-356-2219. For the hearing impaired, call our TTY line at 711 or toll-free at 800-659-8331. You may also contact us by fax at 505-923-8163 or visit our Web site at www. phs.org/fehb.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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 providers' 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 Employees FEHB Insurance Operations, FEHB 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 provider'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 healthcare 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 or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. 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 file a lawsuit 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 800-356-2219 or for the hearing impaired at 505-923-5699 or toll-free at 877-298-7407. We will expedite 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 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and 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 healthcare 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.phs.org/fehb.

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 processes the benefit, 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.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or portal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take corm CA-16 and form OWCP-1500/HCFA=1500 to your provider, or sent it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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 similar federal or state agency determines they much provider; 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.

- **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 or employing 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 BENEFEDS.gov or by phone at 877-888-3337, (TTY 877-889-5680), 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 cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug that is exempt from the requirement of an investigational new drug application.

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. This Plan covers some of these costs, providing the Plan determines the services are medically necessary. For more specific information see page 98. 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 provider and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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 providers 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 Website at www.phs.org/fehb.

We waive some costs if the Original Medicare Plan is your primary payor - We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by providers and other healthcare professionals.

We do not waive any costs if the Original Medicare Plan is your Primary Payor.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
High Option You Pay **Without** Medicare: $0
High Option You Pay **With** Medicare Part B: $0
Standard Option You Pay **Without** Medicare: $500 self only/$1,000 family
Standard Option You Pay **With** Medicare Part B: $500 self only/$1,000 family
Wellness Option You Pay **Without** Medicare: $2,000
Wellness Option You Pay **With** Medicare Part B: $2,000

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **Without** Medicare: $6,350 self only/$12,700 family
High Option You Pay **With** Medicare Part B: $6,350 self only/$12,700 family
Standard Option You Pay **Without** Medicare: $6,350 self only/$12,700 family
Standard Option You Pay **With** Medicare Part B: $6,350 self only/$12,700 family
Wellness Option You Pay **Without** Medicare: $8,150 self only/ $16,300 family
Wellness Option You Pay **With** Medicare Part B: $8,150 self only/ $16,300 family

Benefit Description: Part B Reimbursement Offered
High Option You Pay **Without** Medicare: N/A
High Option You Pay **With** Medicare Part B: N/A
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Part B: N/A
Wellness Option You Pay **Without** Medicare: N/A
Wellness Option You Pay **With** Medicare Part B: N/A

Benefit Description: Primary Care Provider
High Option You Pay **Without** Medicare: $25
High Option You Pay **With** Medicare Part B: $0
Standard Option You Pay **Without** Medicare: $30 copay
Standard Option You Pay **With** Medicare Part B: $0
Wellness Option You Pay **Without** Medicare: First 4 visits: $20 copay, subsequent visits 30% coinsurance
Wellness Option You Pay **With** Medicare Part B: $0

Benefit Description: Specialist
High Option You Pay **Without** Medicare: $50
High Option You Pay With Medicare Part B: $0
Standard Option You Pay **Without** Medicare: $50 copay
Standard Option You Pay **With** Medicare Part B: $0
Wellness Option You Pay **Without** Medicare: $50 copay
Wellness Option You Pay **With** Medicare Part B: $0

Benefit Description: Inpatient Hospital
High Option You Pay **Without** Medicare: $175 copay/day, $500 copay maximum
High Option You Pay **With** Medicare Part B: $0
Standard Option You Pay **Without** Medicare: 30% Coinsurance, Subject to Deductible, $2,000 max per admission
Standard Option You Pay **With** Medicare Part B: $0
Wellness Option You Pay **Without** Medicare: 30% coinsurance
Wellness Option You Pay **With** Medicare Parts B: $0

Benefit Description: Outpatient Hospital
High Option You Pay **Without** Medicare: $300 copay
High Option You Pay **With** Medicare Part B: $0
Standard Option You Pay **Without** Medicare: 30% Coinsurance, Subject to Deductible, $2,000 max per admission
Standard Option You Pay **With** Medicare Part B: $0
Wellness Option You Pay **Without** Medicare: 30% coinsurance
Wellness Option You Pay **With** Medicare Part B: $0

Benefit Description: Incentives Offered
High Option You Pay Without Medicare: N/A
High Option You Pay **With** Medicare Part B: N/A
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Part B: N/A
Wellness Option You Pay **Without** Medicare: N/A
Wellness Option You Pay **With** Medicare Part B: N/A

You can find more information about how our plan coordinates benefits with Medicare in Presbyterian Health Plan at www.phs.org/fehb

- **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 this 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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 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). However, 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 or employing 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 Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)**

  This plan does not offer a Medicare Prescription Plan Employer Group Waiver Plan (PDP EGWP).

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	✓*	
9) Are a Federal employee receiving 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.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity.
- Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- 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 provider and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 23.

Copayments

See Section 4, page 23.

Cost-sharing

See Section 4, page 23.

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.

Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4, page 23.
Experimental or investigational service	The plan evaluates any new procedures, drug therapies, diagnostic genetic testing, 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.
Gender dysphoria	The formal diagnosis used by psychologists and providers to describe people who experience significant **dysphoria** (discontent) with the sex and **gender** they were assigned at birth.
Healthcare professional	A provider or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Infertility	Infertility is a disease characterized by the failure to establish a clinical pregnancy after 12 months of attempting conception via natural methods or artificial insemination for an individual under age 35 or after 6 months for an individual aged 35 or older. First, infertility must be diagnosed. Tests will determine if either partner has reduced fertility. Infertility may be related to female factors (i.e., pelvic adhesion, ovarian dysfunction, endometriosis, prior tubal ligation), male factors (i.e., abnormalities in sperm production, function, or transport or prior vasectomy), a combination of both male or female, or unknown causes. Once the infertility has been diagnosed, treatments for infertility may begin.
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 means the maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the provider as it may be reduced by the co-insurance, deductible or amount beyond the annual maximum. You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprise Act.
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.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

A provider or other healthcare 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 provider 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-service claims and not post-service claims. We will determine whether or not 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 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331 or by accessing our website at www.phs.org/fehb. You may also prove that your claim is an urgent care claim by providing evidence that a provider 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.

Index

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 - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions , limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.phs.org/fehb.
- 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 providers, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by providers: Diagnostic and treatment services provided in the office	Office visit copay: Primary Care Provider $25 - $0 copay per visit for children up to age 26 Specialist $50 - $20 copay 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)	29
Services provided by a hospital: Inpatient	$175/day up to 5 days	61-62
Services provided by a hospital: Outpatient	$150	62-63
Emergency benefits: In-area	$40 urgent care center; $200 for ER visit	66
Emergency benefits: Out-of-area	$40 urgent care center; $200 for ER visit	67
Mental health and substance use disorder treatment:	Regular cost sharing $25 copay per visit $0 copay per office visit for children up to age 26	69-70
Prescription drugs (Retail and Mail Order)	Tier 0 - $0 Maintenance Medication (for certain chronic conditions); Mail order $0 Tier 1 - $10 Generic (Preferred) drugs; Mail order $20 Tier 2 - $100 Brand (Preferred) drugs; Mail order $140 Tier 3 - $125 non-Brand (Non-preferred) drugs; Mail order $200 <u>Tier 4 – Specialty Pharmaceuticals</u> 50% of the plan allowance up to a maximum out-of-pocket of $500 per prescription; Not available mail order	77-79
Dental care	Limited benefit. Applicable provider visit copay	85-86

High Option Benefits	You pay	Page
Vision care	30% of the plan allowance Applicable provider visit copay (eye exam for children).	42-43
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.	87-89
Protection against catastrophic costs (your out-of-pocket maximum)**:**	Nothing after $6,350/Self Only or $12,700/ Self Plus One and Self and Family enrollment per year Some costs do not count toward this protection	23

Summary of Benefits for the Standard Option of the Presbyterian Health Plan - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.phs.org/fehb.
- 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 providers, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by providers: Diagnostic and treatment services provided in the office	Office visit copay: Primary Care Provider $30 Specialist $50 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	29
Services provided by a hospital: Inpatient	30% coinsurance* /$2,000 Max per admission Deductible applies	61-62
Services provided by a hospital: Outpatient	30% coinsurance* /$2,000 Max per surgery Deductible applies	62-63
Emergency benefits: In-area	$40 urgent care center; $250 for ER visit	66
Emergency benefits: Out-of-area	$40 urgent care center; $250 for ER visit	67
Mental health and substance use disorder treatment:	Regular cost sharing $30 copay per visit No deductible	69-70
Prescription drugs (Retail and Mail Order)	Tier 0 - $0 Maintenance Medication (for certain chronic conditions); $0 Mail order Tier 1 - $10 Generic (Preferred) drugs; $20 Mail order Tier 2 - $100 Brand (Preferred) drugs; $140 Mail order Tier 3 - $125 non-Brand (Non-preferred) drugs; $200 Mail order <u>Tier 4 - Specialty Pharmaceuticals</u> 50% of the plan allowance up to a maximum out-of-pocket of $500 per prescription, not available mail order	77-79
Dental care	Limited benefit	85-86

	Applicable provider visit copay	
Vision care	50% of the plan allowance Applicable provider visit copay (eye exam for children).	42-43
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.	87-89
Protection against catastrophic costs (your out-of-pocket maximum):	Nothing after $6,350/Self Only or $12,700/ Self Plus One enrollment or Self and Family enrollment per year. Some costs do not count toward this protection.	23

Summary of Benefits for the Wellness Option of the Presbyterian Health Plan - 2027

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.phs.org/fehb.
- 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 providers, except in emergencies.

Basic Option Benefits	You Pay	Page
Medical services provided by providers: Diagnostic and treatment services provided in the office	Office visit copay Primary Care Provider First 4 visits: $20 copay Subsequent visits: 30% coinsurance* Specialist $50 copay	29
Services provided by a hospital: Inpatient	30% coinsurance*	61-62
Services provided by a hospital: Outpatient	30% coinsurance*	62-63
Emergency benefits: In-area	Urgent care $40 per visit No deductible Emergency First 2 visits: $300 copay No deductible Subsequent Visits: 30% coinsurance Subject to deductible	66
Emergency benefits: Out of the area	Urgent care $40 copay Emergency First 2 visits $300 copay Subsequent Visits: 30% coinsurance*	67
Mental Health and Substance use disorder treatment	Regular cost sharing First 4 visits $20 copay Subsequent visits 30% coinsurance*	69-70
Prescription drugs (Retail and Mail Order)	Tier 0 - $0 Maintenance Medication (for certain Chronic conditions): Mail order $0 Tier 1 - $10 Generic (Preferred) drugs; Mail order $20 Tier 2 - $100 Brand (Preferred) drugs; Mail order $140 Tier 3 - $125 non-Brand (Non-preferred) drugs; Mail order $200 Tier 4 - Specialty Pharmaceuticals 50% of the plan allowance up to maximum of $500 per prescription (Not subject to deductible)	77-79

	Not available mail order	
Dental Care	Limited benefit Applicable provider visit copayment	85-86
Vision	30% of the plan allowance Applicable provider visit copay (eye exam for children).	42-43
Special features:	Flexible benefits option: Services for deaf and hearing impaired, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, cancer clinical trails, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts.	87-89
Protection against catastrophic costs (your out-of-pocket maximum):	Nothing after $8,150/Self Only or $16,300/ Self Plus One and Self and Family enrollment per year Some costs do not count toward this protection	23

2027 Rate Information for - Presbyterian Health Plan

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare**.**

To review premium rates for all FEHB health plan options please go to www. opm.gov/FEHBpremiums or www. opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Central Counties					
High Option Self Only	P21	$352.04	$290.86	$762.75	$630.20
High Option Self Plus One	P23	$767.53	$691.89	$1,662.98	$1,499.10
High Option Self and Family	P22	$843.82	$666.98	$1,828.28	$1,445.12
Central Counties					
Standard Option Self Only	PS4	$352.04	$183.80	$762.75	$398.24
Standard Option Self Plus One	PS6	$767.53	$448.87	$1,662.98	$972.55
Standard Option Self and Family	PS5	$843.82	$415.40	$1,828.28	$900.03
Wellness Option Self Only	PS1	$352.04	$119.05	$762.75	$257.95
Wellness Option Self Plus One	PS3	$767.53	$301.86	$1,662.98	$654.03
Wellness Option Self and Family	PS2	$830.27	$276.76	$1,798.93	$599.64