

# Presbyterian Health Plan

<http://www.phs.org>

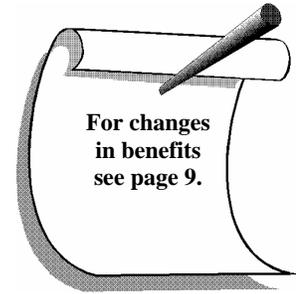
 **PRESBYTERIAN**

**2006**

**A Health Maintenance Organization**

**Serving:** *All counties of New Mexico,  
except for Otero and southern Eddy County*

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



*This Plan has Excellent accreditation from NCQA.  
See the 2006 Guide for more information on  
accreditation.*

**Enrollment code for this Plan:**

**P21 Self Only**

**P22 Self and Family**



Authorized for distribution by the:



**United States  
Office of Personnel Management**

Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>

**RI73-563**

## **Notice of the United States Office of Personnel Management's Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out (“disclose”) your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back (“revoke”) your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints  
United States Office of Personnel Management  
P.O. Box 707  
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

## **Important Notice from Presbyterian Health Plan About Our Prescription Drug Coverage and Medicare**

OPM has determined that Presbyterian Health Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage, thus, you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

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### **Please be advised**

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If you lose or drop our coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period 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](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778.)*

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

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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This brochure describes the benefits of Presbyterian Health Plan under our contract (CS2627) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Presbyterian Health Plan administrative offices is:

Presbyterian Health Plan  
2501 Buena Vista SE  
Albuquerque, NM 87106  
Or  
PO Box 27489  
Albuquerque, NM 87125-7489

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 9. Rates are shown at the end of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 505-923-5678 or toll-free 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street NW Room 6400  
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## Preventing medical mistakes

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

**1. Ask questions if you have doubts or concerns.**

Ask questions and make sure you understand the answers.

Choose a doctor with whom you feel comfortable talking.

Take a relative or friend with you to help you ask questions and understand answers.

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

Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.

Tell them about any drug allergies you have.

Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.

Read the label and patient package insert when you get your medicine, including all warnings and instructions.

Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

**3. Get the results of any test or procedure.**

Ask when and how you will get the results of tests or procedures.

Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.

Call your doctor and ask for your results.

Ask what the results mean for your care.

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

Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.

Be sure you understand the instructions you get about follow-up care when you leave the hospital.

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

Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

Ask your doctor, “Who will manage my care when I am in the hospital?”

Ask your surgeon:

- Exactly what will you be doing?
- About how long will it take?
- What will happen after surgery?
- How can I expect to feel during recovery?

Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- ▶ [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ▶ [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- ▶ [www.talkaboutrx.org/index.jsp](http://www.talkaboutrx.org/index.jsp). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- ▶ [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- ▶ [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- ▶ [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation’s health care delivery system.

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## Section 1 Facts about this HMO plan

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

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

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

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

### **How we pay providers**

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

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

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

The RBRVS pays higher for evaluation and management services and lower for procedures. All physicians receive reimbursement for both evaluation and management services and procedures. The effect upon the individual physician will vary depending upon how much time they spend in office-based services as compared to procedural-based services. Typically, physicians such as primary care physicians, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office-based services, and physicians such as 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**

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

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

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

## **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 is all counties of New Mexico, except for Otero County and southern Eddy County

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

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

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## Section 2 How we change for 2006

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Do not rely 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.

### Changes to this Plan

- Your share of the non-Postal premium will increase by 8.8% for Self Only or 15% for Self and Family.
- The copayment for CAT scans/MRI/PET scans has changed from no copayment to \$50 per test.
- The copayment for Sleep Studies – Overnight stay has changed from \$100 to \$200 per admission.
- The copayment for Preventive care, adult services has changed from \$15 per visit to primary care physician to \$10 per visit to primary care physician and from \$25 per visit to specialist to \$15 per visit to specialist.
- The copayment for Preventive care, children services has changed from \$15 per visit to primary care physician to \$10 per visit to primary care physician and from \$25 per visit to specialist to \$15 per visit to specialist.
- The copayment for inpatient hospital admission has changed from \$100 to \$200.
- The copayment for Emergency Room Care within Service Area Emergency Care at an urgent care center has changed from \$15 per visit to \$25 per visit.
- The copayment for Emergency Room Care within Service Area Emergency Care as an outpatient or inpatient at a hospital, including doctors' services has changed from \$50 per visit to \$75 per visit.
- The copayment for Emergency Room Care outside our Service Area Emergency Care as an outpatient or inpatient at a hospital, including doctors' services has changed from \$50 per visit to \$75 per visit.
- The lifetime maximum for transplants including travel and immunosuppressive drugs is \$500,000.
- Per a New Mexico State mandate, the Plan now provides coverage for human papillomavirus screening once every three years for women age 30 or older.

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## Section 3 How you get care

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### Identification cards

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

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

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and coinsurance, and you will not have to file claims.

- **Plan providers**

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

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

- **Plan facilities**

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

### What you must do to get covered care

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

- **Primary care**

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

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

- **Specialty care**

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services Department immediately at 1-800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 505-923-5699 or 1-877-298-7407. If you are new to the FEHB Program, we will arrange for you to receive care.

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 92<sup>nd</sup> 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

**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.

**Services requiring our prior approval**

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

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

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

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## Section 4 Your costs for Covered services

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You must share the costs of some services. You are responsible for:

### **Copayments**

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

Example: When you see your primary care physician **for non-preventive services**, you pay a copayment of \$15 per office visit and when you go see a specialist, you pay a copayment of \$25 per office visit. When you see your primary care physician **for preventive services**, you pay a copayment of \$10 per office visit and when you go see a specialist, you pay a copayment of \$15 per office visit. When you go in the hospital, you pay \$200 facility copayment per admission.

### **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services and 30% of our allowance for durable medical equipment.

### **Your catastrophic protection out-of-pocket maximum**

After your copayments and/or coinsurance total \$2000 per person or \$4000 per family enrollment in any Calendar year, You do not have to pay any more for Covered services. However, copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Prescription drugs
- Dental services
- Vision services
- Non-covered charges

Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

## Section 5 Benefits

See page 9 for how benefits changed this year. Page 71 is a benefits summary. Make sure you review the benefits that are available in which you are enrolled.

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. 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 our benefits, contact us at 505-923-5678 or toll-free at 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 or at our Web site at [www.phs.org](http://www.phs.org).

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

**Here are some important things you should keep in mind about these benefits:**

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

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians	
<ul style="list-style-type: none"> <li>• Primary Care Physician</li> <li>• Specialist</li> </ul>	<p>\$15 copayment per visit</p> <p>\$25 copayment per visit</p>
Professional services of physicians	
<ul style="list-style-type: none"> <li>• In an urgent care center</li> <li>• During a hospital stay</li> </ul>	<p>\$15 copayment In network \$25 copayment Out of network</p> <p>\$200 copayment per admission (inpatient) (Physician services do not have an additional copayment as the service charges are included in the inpatient hospital/facility admission copayment) \$100 copayment per visit (outpatient) (included in hospital/facility outpatient copayment)</p>
<ul style="list-style-type: none"> <li>• Office medical consultations</li> </ul>	<p>\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist</p>
<ul style="list-style-type: none"> <li>• Second surgical opinion</li> </ul>	<p>\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist</p>
In a Skilled Nursing Facility: Admission must be arranged and preauthorized by the Plan. Skilled Nursing Facility care is provided for up to 60 days per member, <i>per Calendar year</i>	\$200 copayment per admission (Physician charges are included in the inpatient hospital/facility admission copayment)
At home	<p>\$15 copayment per visit by a primary care physician \$25 copayment per visit by a specialist</p>

*Diagnostic and treatment services – continued on next page*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Diagnostic tests are not subject to a copayment regardless of whether an office visit is billed.  If an office visit is billed, the following copayments are taken:  \$15 copayment per visit to primary care physician \$25 copayment per visit to specialist
<ul style="list-style-type: none"> <li>• CAT scans/MRI/PET scans</li> </ul>	\$50 copayment per test
<ul style="list-style-type: none"> <li>• Sleep Studies – Overnight stay</li> </ul>	\$200 copayment per admission
<b>Preventive care, adult</b>	
Routine screenings, such as:	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist
<ul style="list-style-type: none"> <li>• Preventive physical exam</li> </ul>	
<ul style="list-style-type: none"> <li>• Office based health education</li> </ul>	Preventive care services are included in the Preventive care office visit copayment.
<ul style="list-style-type: none"> <li>• Glaucoma Testing</li> </ul>	
<ul style="list-style-type: none"> <li>• Family Planning</li> </ul>	
<ul style="list-style-type: none"> <li>• Blood lead level – One annually</li> </ul>	
<ul style="list-style-type: none"> <li>• Total Blood Cholesterol – once every three years</li> </ul>	
<ul style="list-style-type: none"> <li>• Osteoporosis Screening</li> </ul>	
<ul style="list-style-type: none"> <li>• Colorectal Cancer Screening, including Fecal occult blood test</li> </ul>	
Sigmoidoscopy, screening – every five years starting at age 50	
Double contrast barium enema – every five years starting at age 50	
Colonoscopy screening – every ten years starting at age 50	

*Preventive care, adult – continued on next page*

Preventive care, adult <i>(continued)</i>	You pay
Routine screenings, such as: <ul style="list-style-type: none"> <li>● Chlamydia infection</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.
Routine Pap test Human papillomavirus screening – every three years starting at age 30 Note: The office visit is covered if pap test or human papillomavirus screening is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>● From age 35 through 39, one during this five year period</li> <li>● From age 40 through 64, one every Calendar year</li> <li>● At age 65 and older, one every two consecutive Calendar years</li> </ul>	<b>You pay nothing for mammograms. Additional mammograms are covered when a Plan provider determines that they are medically necessary.</b>
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>● Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>● Influenza vaccine, annually</li> <li>● Pneumococcal vaccine, age 65 and older</li> </ul>	\$10 copayment per visit to primary physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>

Preventive care, children	You pay
<ul style="list-style-type: none"> <li>Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist  Preventive care services are included in the Preventive care office visit copayment.
<ul style="list-style-type: none"> <li>Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist
<ul style="list-style-type: none"> <li>Examinations, such as:</li> </ul>	Preventive care services are included in the Preventive care office visit copayment.
<ul style="list-style-type: none"> <li>Eye exams through age 17 to determine the need for vision correction</li> </ul>	
<ul style="list-style-type: none"> <li>Ear exams through age 17 to determine the need for hearing correction</li> </ul>	
<ul style="list-style-type: none"> <li>Examinations done on the day of immunizations (up to age 22)</li> </ul>	
Maternity care	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>Prenatal care</li> <li>Delivery</li> <li>Postnatal care</li> </ul> Note: Here are some things to keep in mind: <ul style="list-style-type: none"> <li>You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby.</li> <li>You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> <li>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	\$15 copayment per visit up to a maximum of \$150 per pregnancy Specialists (Perinatologist) - \$25 copayment per visit Delivery – Inpatient - \$200 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)
<i>Not covered: Routine sonograms to determine fetal age, size or sex. Circumcisions performed other than during the newborn Hospital stay are only Covered when Medically Necessary.</i>	<i>All charges.</i>

<b>Family planning</b>	
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> </ul>	<p>Outpatient – \$100 copayment per visit (included in hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in Hospital/facility admission copayment)</p>
<ul style="list-style-type: none"> <li>• Surgically implanted contraceptives (Such as Norplant)</li> </ul>	<p>Insertion – 50% of all charges</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>No additional copayment if office visit copayment is already taken.</p>
<ul style="list-style-type: none"> <li>• Injectable contraceptive drugs (such as Depo provera)</li> </ul>	50% of all charges
<ul style="list-style-type: none"> <li>• Intrauterine devices (IUDs)</li> </ul>	50% of all charges
<ul style="list-style-type: none"> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>No additional copayment if office visit copayment is already taken.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling.</i></li> </ul>	<i>All charges.</i>
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> </ul> <p>Artificial insemination is covered up to 3 inseminations.</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>50% of all charges</p>
<ul style="list-style-type: none"> <li>• Fertility drugs</li> </ul> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefits</p>	50% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>– <i>in vitro fertilization</i></li> <li>– <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i></li> <li>– <i>Services and supplies related to ART procedures</i></li> <li>– <i>Cost of donor sperm</i></li> <li>– <i>Cost of donor egg</i></li> </ul> </li> </ul>	<i>All charges.</i>

Allergy care	You pay
<ul style="list-style-type: none"> <li>● Testing and treatment</li> <li>● Allergy injections</li> </ul>	<p>\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist</p> <p>Allergy injections are included in the office visit copayment. If there is no office visit, allergy injections are not subject to a copayment.</p>
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> <li>● Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> <li>● Respiratory and inhalation therapy</li> <li>● Dialysis – hemodialysis and peritoneal dialysis</li> </ul>	<p>\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist</p>
<ul style="list-style-type: none"> <li>● Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>● Specialty Pharmaceuticals (see also Home health services)</li> <li>● Growth hormone therapy (GHT)</li> </ul> <p>Note: – We only cover GHT when we preauthorize the treatment. Growth Hormone is covered for children with growth potential who have total or partial growth hormone deficiency (idiopathic or organic). The diagnosis of growth hormone deficiency must be confirmed by at least two stimulation tests. Growth hormone injections are specifically excluded in member's with Turner's syndrome or Down's syndrome, unless growth hormone deficiency can be documented, and when preauthorized by us. For adults, growth hormone is covered only for non-functioning or surgically removed pituitary glands with demonstrated low levels of growth hormone. Growth hormone injections are excluded for chronic renal failure or other chronic disease regardless of stimulated growth hormone levels.</p> <p>We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3. Continuation of therapy using any drug is dependent upon its demonstrable efficacy.</p>	<p>15% copayment up to a maximum of \$250 per prescription.</p>

Physical and occupational therapies	You pay
<p>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:</p> <ul style="list-style-type: none"> <li>● qualified physical therapists; and</li> <li>● occupational therapists.</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. In-patient or out-patient therapy may be extended 2 additional months if significant improvement is expected to continue and must be preauthorized by PHP</p> <p>Significant improvement means:</p> <ul style="list-style-type: none"> <li>● The patient is likely to meet all therapy goals for the first two months of therapy; or</li> <li>● The patient has met all therapy goals in the preceding two months of therapy, as specifically documented in the therapy record.</li> </ul> <p>This benefit is <i>not</i> renewable each Calendar year.</p> <ul style="list-style-type: none"> <li>● Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions with continuous electrocardiogram (ECG) monitoring and up to 24 sessions with intermittent ECG monitoring at an approved facility.</li> </ul>	<p>\$25 copayment per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Long-term rehabilitative therapy includes treatment of chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not covered. Chronic conditions include, but are not limited to Muscular Dystrophy, Down's Syndrome, and Cerebral Palsy. (Any therapy beyond 4 consecutive months is defined as long term therapy.)</i></li> <li>● <i>Exercise programs</i></li> </ul>	<p><i>All charges.</i></p>
Speech therapy	
<p>Speech Therapy is covered for up to 2 months when provided by a licensed or certified speech therapist subject to the following:</p> <ul style="list-style-type: none"> <li>● Speech Therapy is medically necessary</li> <li>● Speech Therapy <i>must be</i> preauthorized by us</li> <li>● 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.</li> </ul>	<p>\$25 copayment per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Speech Therapy beyond 6 consecutive months.</i></li> </ul>	<p><i>All charges.</i></p>

<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• First hearing aid and testing only when necessitated by accidental injury</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist
<ul style="list-style-type: none"> <li>• Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist
<ul style="list-style-type: none"> <li>• <i>Not covered: All other hearing testing</i></li> </ul>	<i>All charges.</i>
<ul style="list-style-type: none"> <li>• <i>Hearing aids, testing and examinations for hearing aids</i></li> </ul>	<i>All charges.</i>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist
<ul style="list-style-type: none"> <li>• One Eye refraction per year for children under 6 when medically necessary to aid in the diagnosis of certain eye diseases</li> </ul>	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	30% of all charges
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Eyeglasses or contact lenses and after age 17, examinations for them</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> <li>• <i>Replacement of all items referenced in this section due to loss, neglect, theft, misuse, abuse or for convenience.</i></li> </ul>	<i>All charges.</i>
<b>Foot care</b>	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<i>All charges.</i>

Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> <li>● Artificial limbs and eyes; stump hose</li> <li>● Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy</li> <li>● Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</li> <li>● Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> <li>● Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth necessitates replacement.</li> <li>● For diabetics, Covered services include foot appliances, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment.</li> <li>● Penile Prostheses are limited to the reasonable charge for semi-rigid or flexible rod prostheses. Benefits for inflatable penile prostheses may be provided when medically necessary.</li> <li>● Prosthetic Devices will be provided when determined to be medically necessary by the plan physician. Prosthetic devices must be preauthorized by us.</li> </ul>	<p>30% of all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Orthopedic and corrective shoes</i></li> <li>● <i>Arch supports</i></li> <li>● <i>Foot orthotics</i></li> <li>● <i>Heel pads and heel cups</i></li> <li>● <i>Lumbosacral supports</i></li> <li>● <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices, except for gradient compression hose</i></li> <li>● <i>Prosthetic replacements provided less than 3 years after the last one we covered</i></li> <li>● <i>Speech synthesis devices</i></li> </ul>	<p><i>All charges.</i></p>

<b>Durable medical equipment (DME)</b>	
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Preauthorization may be required. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>● Hospital beds;</li> <li>● Wheelchairs;</li> <li>● Crutches;</li> <li>● Walkers;</li> <li>● Blood glucose monitors; and</li> <li>● Insulin pumps.</li> </ul> <p>Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotics Devices is Covered when Preauthorized by PHP and when Medically Necessary due to change in the member's condition, wear or after the product's normal life expectancy has been reached.</p>	30% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.</i></li> </ul>	<i>All charges.</i>
<ul style="list-style-type: none"> <li>● <i>Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience is <b>not Covered</b>. Repair and replacement of items under the manufacturer or supplier's warranty is <b>not Covered</b>. If the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair, additional wheelchair(s) are <b>not Covered</b>. One-month rental of a wheelchair is Covered if a Member owned wheelchair is being repaired.</i></li> </ul>	<i>All charges.</i>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>● Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide and Pre-authorized by us.</li> </ul>	Nothing.
<ul style="list-style-type: none"> <li>● Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	Nothing.
<ul style="list-style-type: none"> <li>● Specialty Pharmaceuticals (see also Treatment therapies see page 21)</li> </ul>	15% copayment up to a maximum of \$250 per injection
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> </ul>	<i>All charges.</i>
<ul style="list-style-type: none"> <li>● <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<i>All charges.</i>

<b>Chiropractic</b>	
<p>Chiropractic Services – 18 visits per year if medically necessary.</p> <ul style="list-style-type: none"> <li>Your Plan physician must determine that your treatment will result in significant improvement in your condition within 2 months</li> </ul>	\$25 copayment per office visit
<ul style="list-style-type: none"> <li>Chiropractic treatment is specifically limited to treatment by means of manual manipulation, by the use of hands, and ultrasound therapy</li> </ul>	\$25 copayment per office visit
<ul style="list-style-type: none"> <li>Subluxation must be documented by chiropractic examination and documented in the chiropractic records</li> </ul>	\$25 copayment per office visit
<ul style="list-style-type: none"> <li>Chiropractic x-rays are only covered when performed by a chiropractor for the following clinical situations, unless clinically relevant x-rays already exist: <ul style="list-style-type: none"> <li>Acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents</li> <li>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</li> <li>Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement</li> </ul> </li> <li>Manipulation of the spine and extremities</li> <li>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$25 copayment per office visit
<p><i>Not covered:</i></p> <p><i>Chiropractic treatment for chronic subluxation or rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions.</i></p> <p><i>Diagnostic or therapeutic service furnished by a chiropractor including magnetherm, or any other mechanical form of treatment</i></p> <p><i>Rolfing</i></p> <p><i>Massage therapy</i></p> <p><i>Naturopathic services</i></p> <p><i>Hypnotherapy</i></p>	<i>All charges.</i>

Alternative treatments	
<p>Acupuncture – 20 visits per year if determined medically necessary by a doctor of medicine or osteopathy, for anesthesia, smoking cessation or chronic or acute pain</p> <p>Acupuncture treatment for other medical conditions will be covered only if the following conditions are met:</p> <ul style="list-style-type: none"> <li>• There is evidence-based medical literature that clearly supports the safety, efficacy and appropriateness of this treatment for the specific medical condition for which authorization is requested</li> <li>• Acupuncture must be part of a coordinated plan of care</li> </ul> <p>Biofeedback is only covered for treatment of Raynaud’s disease or phenomenon and urinary or fecal incontinence</p>	<p>\$25 copayment per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Naturopathic services</i></li> <li>• <i>Hypnotherapy</i></li> </ul>	<p><i>All charges.</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Smoking Cessation coverage is provided for diagnostic services, cessation counseling and pharmacotherapy. Medical services are provided by licensed healthcare professionals with specific training in managing the Member’s Smoking Cessation program.</li> </ul>	<p><i>No copayment for educational classes and programs. Regular plan benefits apply to medical services and prescription drugs.</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Hypnotherapy</i></li> <li>• <i>Over the counter drugs</i></li> <li>• <i>Acupuncture is not covered under the Smoking Cessation Counseling benefit. However, acupuncture for smoking cessation is covered under the acupuncture benefit subject to the acupuncture copayment and benefit limitation</i></li> </ul>	<p><i>All charges.</i></p>

## Section 5(b) Surgical and anesthesia services provided by physicians and other healthcare professionals

### Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for Covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF 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
<p><b>Surgical procedures</b></p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>● Operative procedures</li> <li>● Treatment of fractures, including casting</li> <li>● Normal pre- and post-operative care by the surgeon</li> <li>● Correction of amblyopia and strabismus</li> <li>● Endoscopy procedures</li> <li>● Biopsy procedures</li> <li>● Removal of tumors and cysts</li> <li>● Correction of congenital anomalies (see Reconstructive surgery)</li> <li>● Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Note: Refer to our Web site <a href="http://www.phs.org">www.phs.org</a> for more information regarding coverage and exclusion criteria.</li> <li>● Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information</li> </ul>	<p>Office visit – \$15 copayment per visit to primary care physician</p> <p style="padding-left: 40px;">\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in outpatient hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>

*Surgical procedures - continued on next page*

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</li> <li>• Treatment of burns</li> </ul> <p><b>Note:</b> 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.</p>	<p>Office visit – \$15 copayment per visit to primary care physician  \$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care</i></li> </ul>	<p><i>All charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance of breasts;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>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.</p>	<p>Office visit – \$15 copayment per visit to primary care physician  \$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Surgeries related to sex transformation</i></li> <li>• <i>Claims incurred due to complications of elective cosmetic surgery</i></li> </ul>	<p><i>All charges.</i></p>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures;</li> <li>• TMJ benefit (Limited – Please refer to Section 5(h) Dental Benefits.</li> </ul>	<p>Office visit – \$15 copayment per visit to primary care physician  \$25 copayment per visit to specialist  Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)  Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> </ul>	<p><i>All charges.</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Allogeneic (donor) bone marrow transplants</li> </ul>	<p>Office visit – \$15 copayment per visit to primary care physician  \$25 copayment per visit to specialist  Outpatient - \$100 copayment per visit  Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>

*Organ/tissue transplants – continued on next page*

<p><b>Organ/tissue transplants</b> (<i>continued</i>)</p> <ul style="list-style-type: none"> <li>Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>National Transplant Program (NTP) – All organ transplants must be medically necessary. Transplants will be performed at a site approved by us</li> </ul> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. The plan will pay reasonable and customary charges for hospital, surgical, laboratory and x-ray services for a donor who is not entitled to benefits under any other health benefit plan or policy. Donor charges must result from the medically necessary covered transplant of an organ or body tissue to a member of the plan.</p> <p>Liver travel benefits are available for the transplant recipient and one other person. Transportation costs will be covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be covered for both out-of-state and in-state, up to a maximum of \$150 a day for both combined. All benefits for transportation, lodging and meals are limited to a maximum of \$10,000.</p> <p>All transplants including travel and immunosuppressive drugs are limited to a lifetime maximum of \$500,000.</p>	<p>Office visit – \$15 copayment per visit to primary care physician \$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Donor screening tests and donor search expenses, except those performed for the actual donor</li> <li>Implants of artificial organs</li> <li>Transplants not listed as covered</li> <li>Non-human organ transplants, except for porcine (pig) heart valves</li> <li>Pancreas (Experimental)</li> <li>Pancreas islet cell infusion (Experimental)</li> </ul>	<p><i>All charges.</i></p>
<p><b>Anesthesia</b></p>	<p><b>You pay</b></p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>Hospital (inpatient)</li> </ul>	<p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>Hospital outpatient department</li> <li>Skilled nursing facility</li> <li>Ambulatory surgical center</li> <li>Office</li> </ul>	<p>\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p>

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

### Here are some important things you should keep in mind about these benefits:

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

Benefit Description	You pay
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul>	\$200 copayment per admission
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: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> </ul>	
Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Non-covered facilities, such as nursing homes, schools</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care, except when medically necessary</i></li> </ul>	<i>All charges.</i>

<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>● Operating, recovery, and other treatment rooms</li> <li>● Prescribed drugs and medicines</li> <li>● Diagnostic laboratory tests, X-rays, and pathology services</li> <li>● Administration of blood, blood plasma, and other biologicals</li> <li>● Blood and blood plasma, if not donated or replaced</li> <li>● Pre-surgical testing</li> <li>● Dressings, casts, and sterile tray services</li> <li>● Medical supplies, including oxygen</li> <li>● Anesthetics and anesthesia service</li> </ul> <p>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.</p>	\$100 copayment per visit
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<p>Skilled nursing facility (SNF): 60 days per member per Calendar year</p> <p>Note: We cover Room and board and other necessary services that you require and a SNF provides. The Plan must preauthorize the services that your Plan physician recommends.</p>	\$200 copayment per admission
<i>Not covered: Custodial care or domiciliary care</i>	<i>All charges.</i>

Hospice care	You pay
<p>The following services are covered for in-patient and in-home hospice benefits:</p> <ul style="list-style-type: none"> <li>● Inpatient hospice care</li> <li>● Physician visits by plan hospice physicians</li> <li>● Home health care by approved home health care personnel</li> <li>● Physical therapy</li> <li>● Medical supplies</li> <li>● Drugs and medication for the terminally ill patient</li> <li>● 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</li> </ul> <p>Benefits are provided for in a Plan hospice or facility approved by the plan physician and preauthorized by the plan.</p> <p>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.</p> <p>The hospice benefits period is defined as:</p> <p>Beginning on the date the plan physician certifies that you are terminally ill with a life expectancy of six months or less; and ending six months after it began, or upon death.</p> <p>If you require an extension of the hospice benefit period, the hospice must provide a new treatment plan and the plan physician must recertify your medical condition to us. No more than one additional hospice benefit period will be preauthorized by us.</p>	<p>\$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>● <i>Food, housing and delivered meals</i></li> <li>● <i>Volunteer services</i></li> <li>● <i>Comfort items</i></li> <li>● <i>Homemaker and housekeeping services</i></li> <li>● <i>Private duty nursing</i></li> <li>● <i>Pastoral and spiritual counseling and</i></li> <li>● <i>Bereavement counseling</i></li> </ul>	<p><i>All charges.</i></p>

<b>Ambulance</b>	<b>You pay</b>
Local professional ambulance service when medically appropriate	
<ul style="list-style-type: none"> <li>• Ground Ambulance</li> </ul>	\$50 copayment per occurrence
<ul style="list-style-type: none"> <li>• Air ambulance</li> </ul>	\$100 copayment per occurrence

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## Section 5(d) Emergency services/accidents

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### 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.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for Covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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### 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.

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### 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
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$25 copayment per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul>	\$75 copayment per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$25 copayment per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul>	\$75 copayment per visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>
<b>Ambulance</b>	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	
<ul style="list-style-type: none"> <li>Ground ambulance</li> </ul>	\$50 copayment per occurrence
<ul style="list-style-type: none"> <li>Air ambulance</li> </ul>	\$100 copayment per occurrence
Inter-Facility Transfer:	
<ul style="list-style-type: none"> <li>Ground Ambulance</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>Air Ambulance</li> </ul>	\$100 copayment per occurrence
<i>Not covered: Inter-Facility Transfer Services if not preauthorized</i>	<i>All charges.</i>

## Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**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.
- Be sure to read Section 4, *Your costs for Covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> <li>● Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>● Medication management</li> </ul>	<p>\$25 copayment per visit</p>
<ul style="list-style-type: none"> <li>● Diagnostic tests</li> </ul>	<p>Nothing if received during the office visit or inpatient hospital admission; otherwise applicable physician visit copayment</p>
<ul style="list-style-type: none"> <li>● Services provided by a hospital or other facility</li> <li>● Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>\$200 copayment per admission</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges.</i></p>

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

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

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

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## Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for Covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A Plan provider must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy, (except for out-of-area emergencies), or by mail for a maintenance medication. Mail order medications are available through the Mail Service Pharmacy. You may obtain the name of the Mail Service Pharmacy by calling Member Services at 505-923-5678 or 1-800-356-2219. Order forms are available from the Plans's customer service department.
- **We use a Preferred List.** We cover non-preferred drugs prescribed by a Plan doctor. Prescription medications are prescribed by a Plan provider and dispensed in accordance with the Plan's Preferred List. The Preferred List is a list of generic and brand name medications that we selected to meet patient needs for quality treatment at a lower cost. You may request a copy of this Preferred List by calling Member Services at 1-800-356-2219 or 505-923-5678. An on-line version of our Preferred List is also available at our web site – [www.phs.org](http://www.phs.org) (click on Health Plans, Pharmacy and Formulary).
- We have an open Preferred listing. If your physician believes a name brand product is necessary or there is no generic available, our physician may prescribe a name brand drug from a Preferred List. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Member Services at 505-923-5678 or 1-800-356-2219. An on-line version of our Preferred List is available on our web site – [www.phs.org](http://www.phs.org) (click on Health Plans, Pharmacy and Formulary).
- Prescription medications prescribed by a Plan provider and obtained at a Plan pharmacy will be dispensed for up to a 30 day supply or 100-unit supply, whichever is less, or one commercially prepackaged unit i.e. one inhaler, one vial ophthalmic drops, one vial of insulin). Any amount of medication beyond these quantity limits, even if necessary to obtain a months supply, will be associated with multiple copayments (for example, 200 tablets of a medication or 2 prepackaged inhalers, necessary for a months supply, will be associated with payment of two copayments for that medication).
- Maintenance medications purchased through the mail order option will be for a 90-day supply or 300-units, whichever is less, or 3 commercially prepackaged units. Specialty Pharmaceuticals are not available through the mail order option. If you or your healthcare provider request a brand name drug in place of the generic, you pay the difference in price between the brand and generic, plus the applicable generic copayment.
- These are the dispensing limitations.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

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

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

**A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written or the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

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

**When you do have to file a claim.**

In-Network

Claims' filing is not necessary. You are responsible for paying the Copayment or Coinsurance.

Out-of-network

For services provided by out-of-network providers, you may be required to file a claim if the provider does not do so. To file a claim, complete all questions on the claim form (see sample), sign it, and attach an itemized statement from the provider. Be sure the statement includes all of the following:

- Patient's Name
- Diagnosis
- Date of Service
- Procedure Code
- Price for each procedure
- Name and address of the provider.

A separate claim form is required for each family member.

If the provider's office uses a universal claim form (HCFA-1500), that form may be submitted in lieu of the Presbyterian Health Plan claim form as long as the patient and insured information is completed.

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.

Mail proof to:  
Presbyterian Health Plan  
Attention: Pharmacy  
P.O. Box 27489  
Albuquerque, NM 87125-7489

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Smoking Cessation (limited to two (2) 90-day courses of treatment per Calendar year)</li> <li>• Insulin</li> <li>• Diabetic supplies, including insulin syringes, needles, blood test strips, urine test tape, and acetone test tablets. (Glucose monitors are covered as durable medical equipment, see under Durable Medical Equipment section)</li> <li>• All FDA-approved oral and injectable contraceptive drugs and contraceptive devices</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction when preauthorized by Us</li> <li>• Contraceptive drugs and devices</li> <li>• Fertility drugs, oral or injectable, including those provided in a physician’s office</li> <li>• Injectable drugs or products (Specialty Pharmaceuticals)</li> <li>• Immunosuppressive drugs following transplant surgery</li> <li>• Special Medical Foods are covered when prescribed by a physician for treatment for Genetic Inborn Errors of Metabolism, when used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status, when you are under the physician’s ongoing care and when preauthorized by Us.</li> </ul>	<p>\$10 copayment per generic (Preferred) – 30 day supply or 100 units whichever is less</p> <p>\$20 copayment per brand (Preferred) – listed on the PHP Preferred List – 30 day supply or 100 units whichever is less</p> <p>\$40 copayment Non-preferred – 30 day supply or 100 units whichever is less</p> <p><b>Mail order</b></p> <p>\$20 copayment per generic (Preferred) – 90 day supply or 300 units whichever is less</p> <p>\$40 copayment per brand (Preferred) – listed on the PHP Preferred List – 90 day supply or 300 units whichever is less</p> <p>\$80 copayment Non-preferred – 90 day supply or 300 units whichever is less</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment</p> <p>50% of all charges</p> <p>15% copayment up to a maximum of \$250 per prescription</p> <p>15% copayment up to a maximum of \$250 per prescription (Subject to lifetime transplant maximum)</p> <p>50% copayment</p>

*Covered medications and supplies – continued on next page*

Covered medications and supplies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Vitamins, nutrients and food supplements that can be purchased without a prescription</i></li> <li>• <i>Replacement prescriptions resulting from loss, theft, or destruction</i></li> <li>• <i>Drugs from which there is a nonprescription equivalent available</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>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.</i></li> </ul>	<p><i>All charges.</i></p>

## Section 5(g) Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>24 hour nurse line</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-905-3282 and talk with a registered nurse who will discuss treatment options and answer your health questions. The Nurse Advice Line is confidential. You will be asked to provide some basic information to ensure that you are part of the Presbyterian Health Plan. There is no limit to the number of calls you can make.</p>
<b>Services for deaf and hearing impaired</b>	<p>Contact Member Services at 505-923-5699 or toll-free at 1-877-298-7407</p>
<b>Pregnancies (Including High-Risk pregnancies)</b>	<ul style="list-style-type: none"> <li>• PRESious Beginnings is a statewide program that determines high-risk pregnancies and offers care management, literature and use of videos. Peri-Natal nurses are available for questions Monday through Friday 8:30 a.m. to 5:00 p.m. to assist with high-risk pregnancy questions. For additional information, call 505-724-6500</li> <li>• Doula services are available for Members who deliver at Presbyterian Hospital. For more information, call 505-724-6500.</li> </ul>
<b>Presbyterian Healthcare Services</b>	<p>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 <a href="http://www.phs.org">www.phs.org</a> or call Member Services at 505-923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired 505-923-5699 or toll-free 1-877-298-7407.</p>
<b>Vision discounts</b>	<p>The Access Plan available through Vision Service Plan (VSP) offers vision services at discounted rates through VSP providers. Please refer to the Presbyterian Value Added flyer for more details or visit <a href="http://www.vsp.com">www.vsp.com</a> for further information.</p>
<b>Acupuncture, Chiropractic, Massage Therapy, Meals on Wheels, Fitness Center, Vision and Hearing Hardware discounts</b>	<p>Discounted services are available through Benefit Source and their contracted providers. Please refer to the Presbyterian Value Added flyer or visit <a href="http://www.benefitsource.org">www.benefitsource.org</a> for further details.</p>

## Section 5(h) 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
- Plan dentists must provide or arrange your care.
- We have no Calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for Covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

<b>Accidental injury benefit</b>	<b>You pay</b>
<p>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.</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p>
<b>Dental benefits (Limited)</b>	
<p>Limited dental services will be provided. Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>● Oral surgery medically necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space.</li> <li>● Removal of infected teeth in preparation for certain surgeries or radiation therapy of the head and neck.</li> </ul> <p><b>Temporomandibular Joint Disorders (TMJ)</b></p> <p>The treatment of Temporomandibular 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).</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p>

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

- **Federal Dual Choice Dental Option** – The DentalSource Companion Plan is offered in conjunction with DentalSource and is available to Presbyterian Federal Health Plan Members. **Federal employees now have the choice of three dental plans being offered.** First is the comprehensive DentalSource Companion Indemnity Option, which offers federal employees the freedom to use any dentist of their choice. The second option provides an extremely affordable, comprehensive dental program through a network of dentists. The third option is an Indemnity Plan offered through Companion Life Insurance Company.
    - Indemnity Federal Plan (see any dentist)
      - ▶ DentalSource / Companion Indemnity Federal Plan is a fee for service dental plan that enables you and your family to see any licensed dentist in the world. The plan provides 100% coverage for Preventive Services, 80% coverage for Basic Services and 50% for Major Services. A waiting period applies to major services. The plan has a \$100 lifetime deductible (once it is paid, it never has to be paid again) and a Calendar year maximum of \$1000 per member.
    - Referral Plan
      - ▶ DentalSource Sandia Plan is a referral dental option available to Presbyterian Federal Health Plan Members. DentalSource Sandia Plan features no deductibles, no Claims Forms, no Waiting Periods, no Maximums, and no Pre-existing Condition Exclusions. This comprehensive plan provides reduced out of pocket costs for preventive and diagnostic services, fillings, crowns, and dentures, oral surgery, root canals, gum surgery, and braces for adults and children. Members select a dentist of their choice from a list of participating dentists throughout the community. A dental fee schedule lists each dental procedure with a specific fee, which is paid at the time dental services are received.
- For additional information and customer service call:  
Albuquerque Area: (505) 237-1501  
Outside Albuquerque: 1-888-862-8659
- Indemnity Plan through Companion Life Insurance Company
    - ▶ DentalSource now provides an Indemnity Plan through Companion Life Insurance Company. This plan offers Presbyterian Federal Employees the freedom to use any dentist of their choice. The plan has a \$1000 Annual Maximum and a \$100 Lifetime deductible per person. Presbyterian Federal Members may only enroll during the Federal Open Enrollment Season. Only Presbyterian Federal Employees new hires may enroll after the dental open season has closed and must do so within the first 60 days of employment.
  - Value Added Vision Discount
    - Exams – 20%
    - Glasses – 20% off
    - **Contact Lens Exam** (Fitting and Evaluation) – 15% off
    - **Laser Surgery** (Lasik and PRK) – Average 15% - 20% off
      - ▶ Presbyterian members must use a VSP provider to receive a discount. Discounts are only available through the VSP doctor who provided an eye exam within the last 12 months. To find a VSP provider near you, log on to VSP's website at [www.vsp.com](http://www.vsp.com) or call VSP's Member Services at 1-800-877-7195.

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## Section 6 General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under What Services Require our Prior Approval on page 12.**

We do not cover the following:

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

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## Section 7 Filing a claim for Covered services

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When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

### **Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 505-923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407.

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

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

#### **Submit your claims to:**

**Presbyterian Health Plan  
PO 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**

**PO 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.

**When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

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## Section 8 The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: PO Box 27489 Albuquerque, NM 87125-7489; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol>
<b>3</b>	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul>

Write to OPM at: United States Office of Personnel Management, Insurance Service Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

*The Disputed claims process – continued on next page*

## The disputed claims process (*continued*)

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 physicians' 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.

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 a 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.

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

## 5

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-356-2219 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage”.

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

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

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

### What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

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

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. Your care must continue to be authorized by your Plan PCP, or precertified as required.

**Claims process when you have the Original Medicare Plan** – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

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

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

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

- **Medicare Advantage (Part C)**

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

*Medicare Advantage (Part C) – continued on next page*

**Medicare Advantage  
(Part C) (continued)**

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

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

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

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

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

**Primary Payer Chart**

A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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 ... <ul style="list-style-type: none"> <li>• You have FEHB coverage on your own or through your spouse who is also an active employee</li> </ul>		✓
<ul style="list-style-type: none"> <li>• You have FEHB coverage through your spouse who is an annuitant</li> </ul>	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... <ul style="list-style-type: none"> <li>• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)</li> </ul>		✓
<ul style="list-style-type: none"> <li>• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD</li> </ul>	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... <ul style="list-style-type: none"> <li>• This Plan was the primary payer before eligibility due to ESRD</li> </ul>		✓ for 30-month coordination period
<ul style="list-style-type: none"> <li>• Medicare was the primary payer before eligibility due to ESRD</li> </ul>	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you...</b>		
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	✓	
<b>D. When you are covered under the FEHB Spouse Equity provision as a former spouse</b>	✓	

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

## TRICARE and CHAMPVA

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

- **When other Government agencies are responsible for your care**

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

- **When others are responsible for injuries**

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

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

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## Section 10 Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 9.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive Covered services. See page 9.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	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.
<b>Experimental or investigational services</b>	The plan evaluates any new procedures, drug therapies, treatments, devices, etc. to determine if they are Experimental/investigational in nature. This evaluation includes review of current literature published in peer review journals and appropriate information from governmental regulatory bodies, such as the FDA. We also utilize reliable evidence (consensus of opinion in the medical community) to determine if the procedure, drug therapies, treatments, devices, etc. is contraindicated for the particular indication which it has been prescribed. Please contact the plan for a more detailed explanation of this evaluation process.
<b>Medical necessity</b>	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.
<b>Plan allowance</b>	Plan allowance is the amount we use to determine our payment and your Coinsurance for Covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows: Total allowable charges for plan providers may not exceed the amount the provider service and the non-plan providers, the total allowable charges may not exceed the Plan allowance as determined by the plan for a service.
<b>Us/We</b>	Us and We refer to Presbyterian Health Plan.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11 FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

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

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

See [www.opm.gov/insure](http://www.opm.gov/insure). Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

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

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

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

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

- **When benefits and premiums start** The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2005 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.

- **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.

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

- **Spouse equity coverage** If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, [www.opm.gov/insure](http://www.opm.gov/insure).
  
- **Temporary Continuation of Coverage (TCC)** If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.
  
- **Converting to individual coverage** You may convert to a non-FEHB individual policy if:

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.
  
- **Getting a Certificate of Group Health Plan Coverage** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

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

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## Section 12 Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the Federal **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

### The Federal Flexible Spending Account Program – FSAFEDS

#### What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you or your spouse, if married, can work, look for work or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

#### Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit [www.fsafeds.com](http://www.fsafeds.com) and click on Enroll
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

## What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

## Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The FSAFEDS Calculator at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. The out-of-pocket costs are summarized on page 71 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this plan, typical out-of-pocket expenses include:

Prescription drug and office visit copayments and Durable Medical Equipment coinsurance.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at <https://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp>. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

**Health care expenses**

The HCFSA is Federal Income tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example listed on the prior page, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

**Paperless Reimbursement** – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for the HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

**Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS by email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

## **The Federal Long Term Care Insurance Program**

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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

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## Summary of benefits for the Presbyterian Health Plan - 2006

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

Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
Diagnostic and treatment services provided in the office	Office visit copayment: Primary Care Physician \$15 Specialist \$25	16
<b>Services provided by a hospital:</b>		
• Inpatient	\$200	34
• Outpatient	\$100	35
<b>Emergency benefits</b>		
• In-area	\$75 outpatient hospital visit	39
• Out-of-area	\$25 urgent care center	39
<b>Mental health and substance abuse treatment</b>		
	Regular cost sharing	41
<b>Prescription drugs</b>		
	\$10 Generic (Preferred) drugs \$20 Brand (Preferred) drugs \$40 non-Brand (Non-preferred) drugs	45
<b>Dental care</b>		
	Limited benefit. Applicable physician visit copayment	48
<b>Vision care</b>		
	30% of all charges (materials) Applicable physician visit copayment (eye exam for children).	23
<b>Special features:</b> Flexible benefits option; Services for deaf and hearing impaired, pregnancies, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts		
		47
<b>Protection against catastrophic costs</b> (your out-of-pocket maximum)		
	Nothing after \$2,000/Self Only or \$4,000/Family enrollment per year  Some costs do not count toward this protection	13

## 2006 Rate Information for Presbyterian Health Plan

**Non-Postal rates** apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Code	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Non-Postal Premium</i>	<i>Postal Premium</i>	<i>Postal Premium</i>
		<u>Biweekly</u>	<u>Biweekly</u>	<u>Monthly</u>	<u>Monthly</u>	<u>Biweekly</u>	<u>Biweekly</u>
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
All Counties of New Mexico, except for Otero and Southern Eddy County							
<b>Self Only</b>	<b>P21</b>	<b>\$135.96</b>	<b>\$45.32</b>	<b>\$294.58</b>	<b>\$98.19</b>	<b>\$160.89</b>	<b>\$20.39</b>
<b>Self and Family</b>	<b>P22</b>	<b>\$316.08</b>	<b>\$156.66</b>	<b>\$684.84</b>	<b>\$339.43</b>	<b>\$373.15</b>	<b>\$99.59</b>