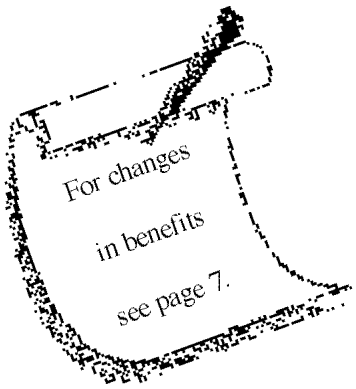
Presbyterian Health Plan 2001

http://www.phs.org

A Health Maintenance Organization



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

Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment codes for this Plan:

P21 Self Only

P22 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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Federal Employees
Health Benefits Program

RI 73-563

Table of Contents

Introduction

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

This brochure describes the benefits of (Presbyterian Health Plan) under our contract (CS 2627) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Presbyterian Health Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 only pay the copayments, coinsurance, and deductibles 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 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. It is the method adopted by our Federal Health Care Finance Administration for Medicare reimbursement.

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 individual affect upon the 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, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office based services while physicians such as surgeons, and cardiologists spend more time in procedure based services. Although this fee schedule is provider and health plan based, it results in a high quality health plan for you and your families.

Who provides my health care?

We operate a mixed model health plan. Doctors provide care in contracted medical centers or in their own offices. We also contract with Physician Directed Teams. This allows primary care medical groups to choose their own network of specialists and hospitals in order to provide all the services required to care for patients.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients'Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (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 is for Profit
- Presbyterian Health Plan is owned by Presbyterian Health Care Services which has been providing quality care for New Mexicans since 1908.
- Presbyterian Health Plan has 14 years'experience in improving the health of individuals, families and communities
- 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. You may also contact us by fax at 505/923-8163 or visit our website at www.phs.org.

Service Area

To enroll with us you must live 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 you 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 services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If you or your dependents live out of area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or HMO that has agreements with affiliates in other areas. Full - Time dependent students attending school outside Presbyterian Health Plan's service area can receive care at a Student Health Center without a referral 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. 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.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed "higher shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800-672-8880 Quality Management, or checking our website www.phs.org. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - •• Speak up if you have questions or concerns.
  - •• Keep a list of all the medicines you take.
  - •• Make sure you get the results of any test or procedure.
  - •• Talk with your doctor and health care team about your options if you need hospital care.
  - •• Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 18.3% for Self Only or 18.4% for Self and Family.
- The annual eye refraction (which includes the written lens prescription) is no longer covered.

Section 3. How you get care

Identification Cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 505-923-5678 or 1-800/356-2219.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and/or 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. To provide ongoing procedures and processes for obtaining, verifying, reviewing and evaluating practitioners' competence and qualifications in order to determine whether they are able to participate on the Plan to provide health care services. This shall 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 website. 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 Physician Directed Teams, 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 website. 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 provider directory who is closest to home or work. Locations and telephone numbers of the participating doctors are listed in the provider directory or can be obtained by calling the Member Services Department 505/923-5678 or 1-800/356-2219. 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.

- **Primary care**

Your primary care physician can be a family Practice, General Practice, Internal Medicine, Pediatrics and OB/GYN acting as a Primary Care Physician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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**

Your primary care physician will refer you to a specialist for needed care. However, you may see a women's healthcare provider who has been credentialed by Presbyterian Health Plan to provide female-related care with out a referral. Treatment for Infertility, Reproductive Endocrinology, and/or Gynecological Oncology may require pre-authorization. You do not need a referral from your PCP or Specialist for an evaluation from behavioral health services; however, you must call 505/923-5470 (Albuquerque area or 1-800-453-4347 (Outside Albuquerque) to access services.

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or for gynecological or maternity care, you must receive a referral from you primary care doctor before seeing any other doctor or obtaining specialty services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will make arrangements for appropriate referrals. All follow-up care must be provided or arranged by the primary care doctor.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will issue a referral that will include the expiration date of the referral and the number of visits. If the consultant suggests additional services or visits, you must first check with your primary care doctor to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand). Do not go to the specialist unless your primary care doctor has given you a referral.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or 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 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.

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 Plan 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 customer service department immediately at 1-800-356-2219 or 923-5678. 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 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person.

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

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain 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 the following services: Durable Medical Equipment, Home Health, Hospice, Home IV/Infusion, Acute Rehabilitation, Outpatient Rehab, Ambulance, Skilled Nursing Facilities and Mental Health/Substance Abuse Care.

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or for gynecological or maternity care, you must receive a referral from you primary care doctor before seeing any other doctor or obtaining specialty services. Your physician must get our approval before sending you to a hospital. Referral to a participating specialist is given at the primary care doctor's discretion. If required medical services are not available from participating providers, the Primary Care Physician must request and obtain written authorization form the Presbyterian Health Plan Medical Director before the Member may receive services. Services of a Non-Participating Provider will not be covered unless this authorization is obtained prior to receiving the services.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. We do not have a deductible.

- **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 durable medical equipment.

Your out-of-pocket maximum

After your copayments and/or coinsurance total $2,000 per person or $4,000 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 out-of-pocket maximum, and you must continue to pay copayments and /or coinsurance for these services:

- Prescription drugs
- Dental services
- Vision Services

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 -- OVERVIEW

(See page 7 for how our benefits changed this year and page 58 for a benefits summary.)

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 claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-356-2219 or at our website at www.phs.org.

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

IMPORTANT

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 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.

IMPORTANT

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per visit
Professional services of physicians • In an urgent care center	$10 per visit $10 in Service Area $15 out of Service Area
• During a hospital stay	Nothing
• In a skilled nursing facility Admission must be arranged and preauthorized by the plan. Skilled Nursing facility Care is provided for up to 60 days per member, per calendar year.	Nothing
• Initial examination of a newborn child covered under a family enrollment	Nothing
• Office medical consultations	$10 per visit
• Second surgical opinion	$10 per visit
At home	$10 per visit

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
• Routine screenings, such as: • Preventive physical exam • Office based health education • Glaucoma Testing • Family Planning. • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50	$10 per visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per visit
Routine pap test **NOTE:** The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per visit

Preventive care, adult continued on next page

Preventive Care, Adult *(Continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per visit **Additional Mammograms are covered when determined to be medically necessary by a participating provider.**
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per visit
Not covered for foreign travel	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 30 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 per visit up to a maximum of $100 per pregnancy
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges.*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	50% of all charges 50% of all charges-insertion $10 per visit-removal 50% of all charges $10 per visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*

Infertility Services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• intravaginal insemination (IVI) •• intracervical insemination (ICI) •• intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs and oral fertility drugs under medical benefits. Artificial insemination is covered for up to three inseminations.	50% of all charges 50% of all charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT and ZIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization.	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy **NOTE:** High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) **NOTE:** We will 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 for 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. Authorization. We will ask that your physician 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 Services requiring our prior approval in Section 3. Continuation of therapy using any drug is dependent upon its demonstrable efficacy.	$10 per visit **NOTE: 10% of all charges for Recombinant DNAand Purified Biological Products.**

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • Provided in-patient or out-patient up to 4 months per condition if significant improvement is expected for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. **NOTE:** We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. In-patient or out-patient therapy may be extended 2 additional months if significant improvement is expected to continue. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 sessions with continuous electrocardiogram (ECG) monitoring or up to 24 sessions with intermittent ECG monitoring at an approved facility.	$15 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see Preventive care, children)	$10 per visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% of all charges
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) Screening performed to determine the need for vision correction. This does not include routine eye exams or refractions performed by eye care specialists.	$10 per visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Replacement of all items referenced in this section due to wear, loss, or damage*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose Orthotic appliances include braces and other external devises used to correct a body function. Benefits will be provided if medically necessary and preauthorized. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. **NOTE:** We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. Prosthetics 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. Penile Prosthesis is limited to the reasonable charge for semi-rigid or flexible rod prosthesis. Benefits for inflatable penile prosthesis may be provided when medically necessary. Prosthetic Devices will be provided when determined to be medically necessary by the plan physician. Prosthetic devices must be preauthorized by us.	20% of all charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics except for members with diabetes* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered* • *speech synthesis devices*	*All charges.*

Durable medical equipment (DME)	**You pay**
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. Under this benefit, we also cover: • hospital beds; • wheelchairs; non motorized • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	20% of all charges
Not covered: • *deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.*	*All charges.*
Home health services	
• 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. Services include oxygen therapy, intravenous therapy and medications. • Services include oxygen therapy, intravenous therapy and medications • Recombinant DNA and Purified Biological Products	Nothing Nothing 10% of all charges
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*

Alternative treatments	You pay
Acupuncture/Meridian Therapy – 20 visits per year if medically necessary by a doctor of medicine or osteopathy, chiropractor or Doctor of Oriental Medicine acting within the scope of his/her license for: anesthesia, chronic or acute pain relief. Both a referral is required from your plan physician and preauthorization from us. Treatment of other medical conditions using Acupuncture or Meridian will be covered only if the following conditions are met: • there is evidence-based medical literature that clearly supports the safety, efficacy and appropriateness of this treatment for the specific medical condition for which authorization is requested. • Accupuncture or Meridian Therapy must be part of a coordinated plan of care	$15 per visit
Chiropractic Services- 18 visits per year if medically necessary. Preauthorization is required. • Your plan physician must determine in consultation with us that your treatment will result in significant improvement in your condition within 2 months. • Following the initial evaluation and 6 sessions, inpatient or outpatient chiropractic treatment may be extended for a period not to exceed 2 additional 6 sessions periods when: 1) preauthorized by us. 2) the plan physician certifies that the therapy is medically necessary and is resulting in significant improvement. The determination of significant improvement will be established if the member has met all therapy goals for the proceeding 6 sessions as documented on the therapy record. • Chiropractic treatment is specifically limited to treatment by means of manual manipulation, by the use of hands, and ultrasound therapy. • Subluxation must be documented by chiropractic examination and documented in the chiropractic record. Radiologic (x-ray) demonstration of subluxation is not required for treatment. • Chiropractic x-rays are only covered if preauthorized. Preauthorization for x-rays performed by a chiropractor will be considered for the following clinical situations, unless clinically relevant x-rays already exist: 1) acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents 2) clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over 1/2 inch, or spine curvature consistent with osteoporotic fractures; or 3) abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.	$15 per visit

Alternative treatments continued on next page

Alternative treatments *(Continued)*	**You pay**
Not covered: • *Chiropractic treatment for chronic subluxation of rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, or chronic lung disease, and other diseases/conditions.* • *Diagnostic or therapeutic service furnished by a chiropractor including magnetherm, or any other mechanical form of treatment* • *rolfing* • *massage therapy* • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
Please See Non-FEHB Section	

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

IMPORTANT

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 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.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- 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. • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns	$10 per visit - Outpatient Nothing - Inpatient
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). **NOTE:** Devices are covered under 5(a).	50% of all charges
NOTE: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	

Surgical procedures continued on next page

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) **NOTE:** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges.*

Oral and maxillofacial surgery	**You pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Pancreas islet cell infusion • Allogeneic bone marrow transplants • 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 • National Transplant Program (NTP) – All organ transplants must be medically necessary. Transplants will be performed at a site approved by us. Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. **NOTE:** We cover related medical and hospital expenses of the donor when we cover the recipient. The plan will pay reasonable and customary charges for hospital, surgical, laboratory and x-ray services for a donor who is not entitled to benefits under any other health benefit plan or policy. Donor charges must result from the Medically Necessary covered transplant of an organ or body tissue to a member of the plan. Limited travel benefits are available for the transplant recipient and one other person. Transportation costs will be covered only if out of state travel is required. Reasonable expenses for lodging and meals will be covered for both out of state and in state, up to a maximum of $150 a day for both combined. All benefits for transportation, lodging and meals are limited to a maximum of $10,000. All transplant benefits, including travel, are limited to a lifetime maximum of $500,000 (including immunosuppressive drugs).	$10 per visit

Organ/tissue transplants continued on next page

Organ/tissue transplants (*Continued)*	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Non-human organ transplants, except for porcine (pig) heart valve*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$10 per visit

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

IMPORTANT

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 physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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 covered in Section 5(a) or (b).
- Hospital Service must be preauthorized by us.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. **NOTE:** If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

Inpatient hospital continued on next page

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **NOTE:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF): 60 days per member per calendar year **NOTE:** Room and board and other necessary services are provided when requires skilled nursing care of the type provided by the facility. Admission to the facility must be arranged by the primary care physician or a physician who the member is referred to and preauthorized by Presbyterian Health Plan.	Nothing
Not covered: custodial or domiciliary care	*All charges.*

Hospice care	You pay
The following services are covered for in-patient and in-home hospice benefits: • Inpatient hospice care • Physician visits by plan hospice physicians • Home health care by approved home health care personnel; • Physical therapy • Medical supplies • Drugs and medication for the terminally ill patient; • Respite care for a period not to exceed five continuous days for every 60 days of hospice care. Only two respite cares are available during a hospice benefit period Benefits are provided for in a participating hospice or facility approved by the plan physician and preauthorized by the plan. The hospice benefit period must begin while you are covered with this benefit, and coverage through the plan must be continued throughout the benefit period in order for hospice benefits to continue. The hospice benefit period is defined as: Beginning on the date the plan physician certifies that you are terminally ill with a life expectancy of six months or less; and ending six months after it began, or upon death. If you require an extension of the hospice benefit period, the hospice must provide a new treatment plan and the plan physician must recertify your medical condition to us. No more than one additional hospice benefit period will be preauthorized by us.	Nothing
Not covered: • *Food, housing and delivered meals;* • *Volunteer services* • *Comfort items* • *Homemaker and housekeeping services* • *Private duty nursing* • *Pastoral and spiritual counseling and* • *Bereavement counseling*	*All charges.*
Ambulance	
Benefits are provided for ambulance transportation approved by the plan. Ground Ambulance Air Ambulance	 $50 copay per occurrence $100 copay per occurrence

Section 5 (d). Emergency services/accidents

IMPORTANT		IMPORTANT

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

What is a medical emergency?

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

What to do in case of emergency:

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

Coverage for services will continue until you are medically stable, 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 will 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 circumstance that prevented you from using our established procedures for obtaining emergency care.

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

No prior authorization 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 referral from a plan provider.

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

Emergencies outside our service area:

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

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

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

IMPORTANT

Benefit Description	You pay after the calendar year deductible...
Mental health and substance abuse benefits	
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. **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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Network Mental health and substance abuse benefits continued on next page

Mental health and substance abuse benefits *(Continued)*	
Preauthorization	To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include: • To access mental health services members simply contact the Presbyterian Health Plan Behavioral Health Unit at 923-5470 or 1-800-453-4347 to receive a referral to a behavioral health provider. The behavioral health provider is responsible for any authorizations.
Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions: • If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage. The transitional period will last for up to 90 days from the date you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.
Limitation	We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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.

IMPORTANT

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

- **Who can write your prescription.** A participating plan healthcare 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 formulary medication. Mail order medications are available through the Mail Service Pharmacy identified in the Doctors and Facilities Directory. Order forms are available from the Plan's customer service department.
- **We use a formulary.** Prescription medications are prescribed by a Plan healthcare provider and dispensed in accordance with the Plan's drug formulary. The formulary 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 formulary by calling Member Services at 1-800-356-2219 or 923-5678.

These are the dispensing limitations.

- Prescription medications prescribed by a Plan healthcare 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 copays (for example 200 tablets of a medication or 2 prepackaged inhalers, necessary for a months supply, will be associated with payment of two copays for that medication).
- Your Plan pharmacist will automatically substitute a FDA approved generic drug, when available, for brand name prescriptions. 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 copay.
- Maintenance formulary 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. Non-formulary medications 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 copay.
- Brand name drugs will be associated with a brand copay, even if a generic equivalent is not available
- 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 for such from the plan. Replacement prescriptions resulting from loss, theft, or destruction are not a covered benefit.

Prescription drug benefits continued on next page

Prescription drug benefits *(Continued)*

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

In-Network

No claims filling is necessary. The member is responsible for paying the copayment or coinsurance.

Out-of-Network

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

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

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin, with a copay charge applied to each vial • 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 DME section) • All FDA-approved oral and injectable contraceptive drugs and contraceptive devices • Disposable needles and syringes needed to inject covered prescription medication • Drugs for sexual dysfunction (see Prior authorization below) • Fertility drugs, oral or injectable, including those provided in a physician's office • Injectable drugs or products (recombinant DNA & Purified Bilological Products)	$5 per generic- 30 day supply or 100 units whichever is less $15 per brand -30 day supply or 100 units whichever is less **Mail order** $10 per generic- 90 day supply or 300 units whichever is less $30 per brand –90 day supply or 300 units whichever is less **NOTE:** If there is no generic equivalent available, you will still have to pay the brand name copay. 50% of all charges for Fertility Drugs 10% of all charges for DNA& Purified Biological Products
Here are some things to keep in mind about our prescription drug program: • 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. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary 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 Service at 505-923-5678 or 1-800-356-2219.	

Covered medications and supplies continued on next page

Covered medications and supplies *(Continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements that can be purchased without a prescription* • *Nonprescription medicines* • *Replacement prescriptions resulting from loss, theft, or destruction* • *Drugs for which there is a nonprescription equivalent available* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication, including nicotine patches*	*All charges.*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	Contact Member Services at 1-800-356-2219 or 505-923-5678 and indicate that you require services.
High risk pregnancies	PRESious Beginnings is a statewide program that determines high risk pregnancies and offers case management, literature and use of videos. Peri-Natal nurses are available for questions Monday through Friday 8:30A to 5:00P to assist with high risk pregnancy questions. For additional information, call 1-505-724-6500.

Section 5 (h). Dental benefits

IMPORTANT

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 nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

IMPORTANT

Benefit Description	You pay
Accidental injury benefit	
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.	$10 per visit
Dental benefits	
We have no other dental benefits.	

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 out-of-pocket maximums.

- DentalSource Dental Plan, Inc. is a discount referral dental plan available to you if you are enrolled in our Plan. You select a dentist from a list of participating dentists throughout the community. Copayments are paid at the Dental Office at the time services are received.

  The DentalSource Dental Plan features: no deductibles, no claims forms, no waiting periods, no maximums, and no pre-existing condition exclusions. It is a comprehensive plan including preventive and diagnostic servies, restoratives, dentures, oral surgery, endodontists, periodontists, and orthodontics for adults and children.

- ECCAManaged Vision Care is a discount referral vision plan that is automatically available to you if you are enrolled in our Plan. Through the FEHB program. It is available at no additional costa and allows for discount on Annual Wellness Exams along with discounts on materials. Services are provided by Eye Master and other select providers throughout New Mexico. For additional information and customer service call 1-800-340-0129

- The following health education classes are available to you. Pre-registration is required (except for aerobics and yoga). You can register by calling 823-8408.

  1. DIABETES 4 WEEK PROGRAM - **DIET INCLUDED**
  (Free to members. $25 for non-members.)

  2. SMOKING CESSATION 6 WEEK PROGRAM
  (A one time co-pay for members. $10 for non-members.)

  3. WEIGHT MANAGEMENT
  (Free to members. $10 for non-members.)

  4. CPR
  ($25 for members. $35 for non-members.)

  5. AEROBICS
  ($2 for members per class. $3 for non-members per class. Punch card $20 for 12 classes.)

  6. YOGA
  ($7 for members per class. $8 for non-members per class. Punch card $72 for 12 classes.)

  7. PERSONALTRAINING
  Continuous by appointment. Call 823-8413 to schedule your appointment.

  8. ASTHMA MANAGEMENT (Adult)
  (Free to members. $15 for non-members.)

  9. ASTHMA MANAGEMENT (Adolescent)
  (Free to members. $15 for non-members.)

  10. ASTHMA MANAGEMENT (Pediatric)
  (Free to members. $15 for non-members.)

Section 6. General exclusions -- things we don't cover

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 PriorApproval on page 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are 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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-356-2219.

When you must file a claim -- such as for out-of-area care -- 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 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.

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**
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.

Section 8. The disputed claims process

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:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Presbyterian Health Plan PO Box 27489 Albuquerque, NM 87125-7489; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) 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.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

The disputed claims process continued on next page

Section 8. The disputed claims process *(Continued)*

Step	Description
	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 different claims, 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 provide 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.
6	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. 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 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 can call OPM's Health Benefits Contracts Division IV at 202/606-2343 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered 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.

• What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare managed care is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, 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.

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original 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 either you -- or your covered spouse -- are age 65 or over and...	**Then the primary payer is...**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✔
2) Are an annuitant,	✔	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✔	
b) The position is not excluded from FEHB		✔
Ask your employing office which of these applies to you.		
4) 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),	✔	
5) Are enrolled in Part B only, regardless of your employment status,	✔ (for Part B services)	✔ (for other services)
6) 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,	✔ (except for claims related to Workers' Compensation)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✔
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✔	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✔	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant	✔	
b) Are an active employee		✔

Please note, if your plan physician does not participate in Medicare, you will have to file a claim with Medicare

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

- 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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-356-2219.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments, coinsurance, or deductibles. You must use our provider network to receive secondary benefits from us.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan. 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 managed care plan service area.

• Enrollment in Medicare Part B

NOTE: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

Coordinating benefits with other coverage continued on next page

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 OWCPor similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

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

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.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Custodial care

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.

Experimental or Investigational services

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.

Medical necessity

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

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. 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 providerservice and for non-plan providers, the total allowable charges may not exceed the plan allowance as determined by the plan for a service.

Us/We

Us and we refer to Presbyterian Health Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition

We will not refuse to cover the treatment of a condition that you had limitation 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. 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:

- 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 health 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**.**

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants'premiums begin on January 1.

FEHB facts continued on next page

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

- **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. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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.

- **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.

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

  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.

FEHB facts continued on next page

• 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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 800/356-2219 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalty for fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for Presbyterian Health Plan - 2001

- **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
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay; $10 primary care	13
Services provided by a hospital:		
• Inpatient	Nothing	30
• Outpatient	Nothing	31
Emergency benefits:		
• In-area	$25 outpatient hospital visit	35
• Out-of-area	$15 urgent care center	35
	$10 doctor's office	
Mental health and substance abuse treatment	Regular cost sharing	36
Prescription drugs	$5 formulary generic	38
	$15 formulary brand name and non-formulary	
Dental Care	No benefit	43
Vision Care	No benefit	
Special features: Flexible benefits option, Services for deaf and hearing impaired, high risk pregnancies		42
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,000/Self Only or $4,000/Family enrollment per year	11
	Some costs do not count toward this protection	

2001 Rate Information for

Presbyterian Health Plan

Non-Postal rates apply to most non-Postal enrollees. 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 special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and 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. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	**Code**	**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							
Self Only	P21	**$73.16**	**$24.38**	**$158.51**	**$52.83**	**$86.57**	**$10.97**
Self and Family	P22	**$190.79**	**$63.59**	**$413.37**	**$137.79**	**$225.76**	**$28.62**