Physicians Health Services of New Jersey, Inc.

http://www.phshealthplans.com

2001

A Health Maintenance Organization

Serving: *All of New Jersey*

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

Enrollment codes for this Plan:

2F1 Self Only
2F2 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 73-687

Table of Contents

Introduction

Physicians Health Services of New Jersey, Inc.
One Far Mill Crossing
Shelton, CT 06484

This brochure describes the benefits of Physicians Health Services (PHS) under our contract (CS 2738) 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 PHS.

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.

Who provides my health care?

All medical care, including hospitalization, must be provided by a PHS Plan physician or provider and when appropriate, prior authorized by the PHS Medical Director.

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.

- PHS contracts with physicians and other practitioners either directly or through provider organizations (IPAs and PHOs). Most of these providers are reimbursed for each covered service on a fee-for-service basis with a limited percentage withheld as a reserve. The withheld percentage is based on an estimate of overall utilization. However, some IPAs/PHOs may reimburse their Primary Care Providers on the basis of a set amount per member per month (capitated reimbursement). Depending upon the overall utilization of members selecting PHS's directly contracted or an IPAs/PHOs Primary Care Providers, the amount withheld by PHS may be returned to the providers. PHS also contracts with certain vendors and suppliers (laboratory services, home health, etc.) that are paid a capitated reimbursement. Lastly, PHS reimburses hospitals and facilities on the basis of a per diem, case rate, or some other form of negotiated fee.

If you want more information about us, call (877) 747-9585, or write to Physicians Health Services of New Jersey, Inc., One Far Mill Crossing, Shelton, CT 06484. You may also contact us by fax at (203) 381-6769 or visit our website at www.phshealthplans.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. Our service area is: the State of New Jersey. Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

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 patient cost sharing and shorter 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 the Customer Service Department at (877) 747-9585, **or** checking our website www.phshealthplans.com. 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 11.7% for Self Only or 11.7% for Self and Family.
- Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 90-day maximum. One copayment will be due for each 30-day supply of prescription drugs received
- Emergency services received at an urgent care center will increase to a $25 copayment.

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 (877) 747-9585.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **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.

What you must do

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 obtain covered services from a Plan physician or provider, except in the event of an emergency. If covered services cannot be provided by a Plan physician or Plan provider prior approval must be obtained in writing from the PHS Medical Director before you may receive covered services from a Non-plan physician or provider. PHS will only approve a referral to a Non-plan physician or provider if the covered services cannot be provided by a plan physician or provider.

To see whether a physician or provider participates in the PHS network, or to check the location and phone number of a network specialist, hospital or urgent care center you can:

- Refer to the PHS physician and provider directory;
- Call the Customer Service Department at (877) 747-9585. The Customer Service Department can also provide you with information regarding professional qualifications and credentials;
- Visit our website at www.phshealthplans.com for the latest information on Plan physicians and providers;
- Call the Interactive Provider Directory system toll-free at (800) 686-9847 for a personalized list of local Plan physicians and providers that can be faxed to you immediately or mailed to your home.

- **Primary care**

Your primary care physician can be an internist, family or general practice physician, an obstetrician/gynecologist or a pediatrician for your children.

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**

Although you are not required to obtain a referral from your primary care physician to see a specialist, we recommend that you always consult your primary care physician first.

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 work with your specialist to develop a treatment plan that allows you to see your specialist. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- You may request access to a specialist to coordinate your care or access to a specialty care center if you have a life-threatening or degenerative and disabling condition or disease which requires specialized medical care over a prolonged period of time. Specialty care may be accessed in accordance with the terms of your Plan documents.

- 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 or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

Your 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 (877) 747-9585. 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 benefits 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 prior approval Your physician must obtain prior approval for the following services including, but not limited to: inpatient hospitalization, elective outpatient surgical procedures, oxygen and related respiratory equipment, organ transplants, rehabilitative and restorative physical, occupational, speech, respiratory therapy and skilled nursing care.

PHS will provide the Plan physician or provider with an approval specifying the services requested. The Plan physician or provider will be notified prior to the initiation of the requested treatment. Any covered services received from a Non-Plan physician or provider must also be prior authorized by PHS. The member shall be fully responsible for the cost of services to Plan providers if prior approval for such services has been denied by PHS and the member has been notified of such determination in advance of 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**	We do not have a deductible
· **Coinsurance**	We do not have coinsurance.

Your out-of-pocket maximum for copayments

After your copayments total $1,200 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs

Be sure to keep accurate records of your copayments 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 51 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 (877) 747-9585 or at our website at www.phshealthplans.com. .

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.
- 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
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • Office medical consultations • Second surgical opinion	$10 per office visit
• At home • During a hospital stay • Initial examination of a newborn child covered under a family enrollment	Nothing
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	You pay
Routine screenings, such as: • 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 office visit
Prostate Specific Antigen (PSA test) – one annually for men who are symptomatic; whose biological father or brother have been diagnosed with prostate cancer; and for all men age 50 and over	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services*, above.	$10 per office visit
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 and older , one every calendar year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine Immunizations, and boosters such as: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: ••Eye exams through age 19 to determine the need for vision correction. ••Ear exams through age 19 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 office 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 10 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).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*intracervical insemination (ICI)* ••*intrauterine insemination (IUI)* • Fertility drugs are covered under the Prescription Drug Benefit only when administered in connection with the treatment of a covered infertility service, such as IUI	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Fertility drugs used as part of excluded infertility treatment, such as in vitro fertilization* • *Cost of donor sperm*	*All charges.*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• 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 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) is covered under the Prescription Drug Benefit • Lyme disease treatment that is medically necessary and appropriate including at least 30 days of intravenous antibiotic therapy, and/or 60 days of oral antibiotic therapy. Coverage shall include further treatment by a board-certified rheumatiologist, infectious disease specialist or neurologist	Nothing

Rehabilitative therapies	You pay
Short term rehabilitative therapy (physical, cognitive and occupational) is provided on a inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • For the services of each of the following: ••qualified physical therapists; ••occupational therapists. Speech therapy will be provided to treat speech impairments or loss of organic origin and as the result of conditions such as injury, stroke or tumor removal, for a maximum period of 90 consecutive days from the beginning of therapy with prior approval from the PHS Medical Director. ••speech 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. Cardiac rehabilitation on an outpatient basis, as part of an approved cardiac rehabilitation program for a maximum of 12 weeks following a myocardial infarction or cardiac surgery.	$10 per office 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 19 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
Vision therapy services (orthoptics and/or pleoptic therapy) are covered to a maximum of three (3) visits per member per calendar year. This is not intended to exclude coverage for medically necessary and appropriate treatment for diseases of the eye.	$10 per office visit
One routine eye examination (including refraction) per calendar year for members to the attainment of 19 years of age; One routine examination (including refraction) every two calendar years for members 19 years of age and older (see preventive care)	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 19, examinations for them* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office 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	
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • External prosthetic devices, such as artificial limbs, are limited to a maximum payment by the Plan of $5,000 for the initial appliance and $500 per necessary replacement prosthetic. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*

Durable medical equipment (DME)	You pay
Durable Medical Equipment such as wheelchairs and hospital beds, and orthopedic devices such as braces, external breast prostheses and surgical bras are limited to the initial appliance or piece of equipment.	50% of the cost of the covered item to a maximum of $1,500 per member per calendar year
Not covered: • *Motorized wheel chairs*	*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.	Nothing
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	
• Acupuncture services are covered when approved in advance up to 20 visits per member per calendar year.	$20 per office visit
• Chiropractic services are covered up to 30 visits per member per calendar year. Prior approval is required after the initial visit.	$10 per office visit
Not covered: • *Hypnotherapy* • *Biofeedback* • *Naturopathy Services*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes outpatient self-management training, which includes, but is not limited to, education and medical nutrition therapy. Diabetic self-management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes. Therapy visits are limited to those visits that are medically necessary and appropriate.	$10 per office visit

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.
- 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.).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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 • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per office visit; nothing for inpatient hospital visits
• Voluntary sterilization 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.	$10 per office visit; nothing for inpatient hospital visits
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You pay
• 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.	$10 per office visit; nothing for inpatient or outpatient hospital surgical visits
• 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.	See above.
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	
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.	$10 per office visit; nothing for inpatient hospital visits
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 • Allogeneic (donor) 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 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.	Nothing
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* • *Transportation costs*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in – • Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember 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).

YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior approval.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; • meals and special diets • special duty nursing when medically necessary; and • private room when medically necessary NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
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
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
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: Rehabilitative and restorative physical, occupational, speech, respiratory therapy and skilled nursing care is limited to a combined maximum of 90 days per calendar year, when prior approval is obtained from PHS and when services are performed in a Plan inpatient facility. Up to 60 days may be used for inpatient rehabilitation (physical, occupational, speech, respiratory therapy).	Nothing
Not covered: custodial care	*All charges*

Hospice care	You pay
Supportive and pallative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

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.
- 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

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:

Emergencies within our service area: If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified. If you need to be hospitalized in a Non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in a Non-Plan facility and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from Non-Plan providers in a medical emergency only if delay in reaching Plan provider wold result in death, disability or significant jeopardy to your condition.

Plan pays reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay $50 per emergency room visit, $25 per urgent care center visit or $10 copay per doctor's office visit for emergency care services that are covered benefits by this Plan. If the emergency results in admission to a hospital, the emergency room copay is waived.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of an injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in Non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. To be covered by this Plan any follow-up care recommended by Non-Plan providers must be prior authorized by the Plan or Plan providers. If you are hospitalized in Non-Plan facilities and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan any follow-up care recommended by Non-Plan providers must be prior authorized by the Plan.

Plan pays reasonable charges for emergency care services to the extent the services would have been covered if received by Plan providers.

You pay $50 per emergency room visit, $25 per urgent care center visit or $10 copay per doctor's office visit for emergency care services that are covered benefits by this Plan. If the emergency results in admission to a hospital, the emergency room copay is waived.

	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital emergency room including doctor's services, copay is waived if admitted	$50 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital emergency room including doctor's services, copay is waived if admitted	$50 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 necessary. See 5(c) for non-emergency service.	Nothing
Not covered: air ambulance	*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 PRIOR APPROVALOF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. 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

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• 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.*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Your Plan physician will request prior approval from us for all necessary services. The service must be approved before it is rendered to receive coverage. You, or a provider acting on your behalf, may call our Prior Approval Department at (800) 438-7886 for information. You will be notified of any denials.

Although you are not required to obtain a referral from your PCP to see a specialist, we recommend that you always consult your PCP first.

In this plan, you must see Plan physicians and providers, except in the event of a medical emergency, or when we have authorized the services to be performed by Non-Plan providers because the service is not available from Plan providers.

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:

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan 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 and will end 90 days after 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 licensed Plan physician or referral doctor must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or through the PHS mail order supplier.
- **We use a formulary.** The Plan uses a formulary that includes generic and preferred name brand drugs. The Plan's Pharmacy and Therapeutics Committee meets on a quarterly basis to review new medications to be added to or deleted from the formulary.

  Reviews for additions to the formulary are based primarily on the following:

  1. new drug therapies introduced;
  2. changes in existing drug therapies; and
  3. requests received from Plan physicians

  The criteria used are the safety and efficacy of the drug, other similar products available, and the relative cost. Deletions are decided by the committee based on low utilization, other types of equivalent therapy available, or negative changes in existing drug therapies. Your doctor can ask for exceptions to the formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor.

  Please Note: All brand name drugs that are not listed in the preferred drug formulary will be subject to the highest copayment.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 90-day maximum. You pay a $10 copayment per prescription unit or refill for generic formulary drugs, $20 for preferred brand name drugs, and $35 for all others. One copayment will be due for each 30-day supply of prescription drugs received at a Plan pharmacy. The cost of prescriptions filled through the Plan's mail order supplier will be equal to 2 copayments for a 90-day supply .When you have to file a claim. You nornally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you do receive a bill and need to file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

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 • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior approval below) • Oral contraceptive drugs and devices • Diabetic equipment and supplies, including glucose test tablets and test tape, Benedict's solution or equivalent, acetone test tablets, insulin pumps and appurtenances, infusion devices, blood glucose, glucose monitors, and additional diabetes equipment and supplies as listed by the Department of Health • Fertility drugs used in connection with covered infertility treatments, such as IUI. Note: – We will only cover Growth Hormone Therapy when we prior authorize the treatment. Call (877) 747-9585 for prior approval. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	$10 for generic drugs. $20 for preferred brand name drugs $35 for all other covered drugs

Covered medications and supplies *(continued)*	**You pay**
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 (877) 747-9585.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs for which there is a nonprescription equivalent available* • *Drugs obtained at a Non-Plan pharmacyu except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medications including nicotine patches* • *Fertility drugs used as part of excluded infertility treatment, such as In-Vitro Fertilization.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
24 hour Personal Health Advisor line	Our free Personal Health Advisor phone line is available 24 hours a day, seven days a week to answer your health-related questions. If you are sick or have been hurt, and are unsure of what to do, a specially trained nurse can help you determine the most appropriate course of action. The 550 nurses that staff the phones average more than 15 years of clinical experience. Together, they handle 2 million calls every year. If you ever need help assessing an injury or illness, call the Personal Health Advisor line, toll-free at (800) 219-5326.
Interactive Provider Directory	Even when you do not have access to our printed directory or to the Internet, you can still locate a Plan physician or provider. Our Interactive Provider Directory system via touch-tone phone enables you to have a personalized list of local physicians or providers either faxed to you immediately or mailed to your home. The system will find 100 closest Plan Providers to the zip code you supply. To access the Interactive Provider Directory, call toll-free, (800) 686-9847.
Disease State Management Programs	Disease State Management programs help members manage their chronic conditions. When you are facing the challenges of diabetes, congestive heart disease, asthma, glaucoma, osteoporosis, kidney disease and other chronic conditions, we can help with our education and care-management program. For more information, call toll-free (800) 573-2177
Services for deaf and hearing impaired	Services for the deaf and hearing impaired can be accessed by calling (888) 747-2424

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 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

Accidental injury benefit	You pay
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.	Nothing
Dental benefits	
When Prior Approval is granted by the PHS Medical Director, coverage for medically necessary and appropriate general anesthesia, nursing and related hospital services for certain dental procedures when recommended by the treating dentist or oral surgeon and the member's primary care physician, providing the following conditions are met: • the member is a child under the age of 5 who is determined by their licensed dentist and primary care physician to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital; or • the member has a developmental disability, as determined by their primary care physician that places the member at serious risk. The expense of such anesthesia, nursing and related hospital services shall be deemed a covered service or medical expense.	$10 for outpatient services; nothing for inpatient services.

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

The PHS "Healthy Extras" Program

- **PHS AlternaCare℠**: This holistic health care program provides benefits for chiropractic and acupuncture services, and offers discounts for massage therapy, nutritional supplements and vitamins.

- **TruVision℠:** Get contact lenses and related supplies for up to a 50-percent savings. They are shipped directly to you, at no additional cost.

- **Fitness Center Discount Program:** Receive 20 to 30 percent off monthly fees at participating fitness centers through a health and fitness network administered by WellQuest, Inc.

- **Well Women For Life:** PHS leads the way in meeting the unique health needs of women with our breast cancer screening program and reminder mailings for mammograms and cervical cancer screenings. Osteoporosis and menopause education materials also are available.

- **Smart Start:** This reminder program helps parents keep track of their children's immunizations and provides educational material explaining the importance of receiving these immunizations prior to age two.

- **WellBaby℠:** This program helps members have the healthiest possible pregnancies by complementing the advice and care of the obstetricians.

Dental Care Services

PHS members may enroll in Dent/Pro Plus, a comprehensive dental program offered by International Healthcare Services, Inc. (IHS). The Dent/Pro Plus program provides members with access to a wide range of dental benefits with a special emphasis on preventive dentistry. Benefits are available for preventive, basic and major care, including orthodontics. To enroll with Dent/Pro Plus, simply complete the enclosed dental application and send it directly to International Healthcare Services, Inc., Attn: Sue Merkle, 60 Charles Lindbergh Blvd., Uniondale, NY, 11553. Be sure to select a family dentist from their list since all covered services must be rendered by a participating general dentist. The following is an example of some of the benefits your available for services rendered by a participating dentist:

Diagnostic and Preventive Services		**Restorative Dentistry Primary And Permanent**	
Full mouth x-rays	No Charge	Silver amalgam, one surface	$15.00
Oral exam (every 6 months)	No Charge	Silver amalgam, two surfaces	$30.00
Cleaning of teeth	No Charge	Silver amalgam, three surfaces or more	$45.00
Fluoride treatment	No Charge	Composite filling, one surface	$15.00
Oral Surgery		**Orthodontics**	
Routine extractions per tooth	$35.00	Maximum case fee – 24 months	$1,950.00
Surgical Extraction	$65.00		

Dependent children covered to age 19, or to age 23 if full time students.

Dent/Pro Plus materials have been provided by International Healthcare Services, Inc., for your review and consideration. IHS is not affiliated with PHS or Foundation Health Systems, Inc. IHS is solely responsible for coverage, plan designs, provider network and all other services it offers. If you have questions about Dent/Pro Plus, please call an IHS representative at (800) 468-0600.

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 Prior approval 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, hospital and prescription drug 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 (877) 747-9585.

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: Physicians Health Services of New Jersey, Inc.
One Far Mill Crossing
Shelton, CT 06484

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 prior approval:

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: Physicians Health Services of New Jersey, Inc., One Far Mill Crossing, Shelton, CT 06484; 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)*

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 prior approval, then call us at (877) 747-9585 and we will expedite our review; or

(b) We denied your initial request for care or 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 III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

· 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, or	✓	
b) Are an active employee		✓

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 (877) 747-9585 or visit our website at www.phshealthplans.com
- In this case we do not waive any out-of-pocket costs.

- **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 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, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments or coinsurance.

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

TRICARE

TRICARE is the health care program for 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 OWCP or 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.

Covered services

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

Custodial care

Any service or supply that can be furnished by someone who has no professional health care training or skills to a Member:

a. whose functional capacity has been reduced so significantly that he or she is not able to function outside a protected, monitored, or controlled environment (whether in an institution or in the home) and;
b. who is not under active and specific treatment that will increase the Member's functional capacity to the extent necessary to enable the Member to function outside the protected, monitored or controlled environment.

A Custodial Care determination is not precluded by the fact that a Member is under the care of a supervising or attending physician and that the services are being ordered and prescribed to support and generally maintain the Member's comfort or ensure the manageability of the Member. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided or supervised by a registered nurse, a physician assistant or physical therapist.

Experimental or Investigational

Experimental or investigational services are those services or supplies which include, but are not limited to, any diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies which are determined, in the sole discretion of PHS to be Experimental or Investigational. Services are considered to be Experimental or Investigational if any of the following applies:

- The service or supply has not been formally approved by, or cannot be lawfully marketed without the approval of the appropriate government regulatory body or agency, including but not limited to, the U.S. Food and Drug Administration and, at the time it is furnished, such approval has not been given; or
- The written informed consent form to be used by the treating facility or by other facilities in studying substantially the same service or supply, refers to such service or supply as Experimental or Investigational, or as a research project, a study, an investigation, a test, a trial, or words of similar effect; or
- The written informed consent form and/or the written protocols to be utilized by the treating facility for specific services or supplies has not been reviewed and/or has not been approved by the treating facility's Institutional Review Board, or other body serving a similar function, or if federal law requires such review and approval; or
- The informed consent documents and/or the written protocols and/or published reports or peer review articles in authoritative medical and scientific literature show that the service or supply is the subject of a protocol(s) or study, including Phase I, II, or III clinical trial study,

or is otherwise under study to determine any of the following: its maximum tolerated toxicity, its safety, its efficacy, or its overall benefits and risks as compared with a standard means of treatment or diagnosis.

In determining whether services or supplies are Experimental or Investigational, PHS will evaluate the services with regard to the particular Illness or disease involved, and will consider factors which PHS determines to be most relevant under the circumstances, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocol(s) used by the treating facility or being used by another facility studying substantially the same drug, device, medical treatment or procedure.

Medical necessity

Health care services or supplies for prevention, diagnosis, or treatment which are not excluded or limited by the Contract and which are:

a. appropriate for, and consistent with, the symptoms and proper diagnosis or treatment of the Member's Illness, injury, disease, or condition; and
b. provided for the diagnosis or the direct care and treatment of the Member's Illness, injury, disease, or condition; and
c. not primarily for the convenience, appearance, or recreation of the Member, the Member's practitioner or another; and
d. within the standards of good medical practice within the organized medical community; and
e. neither Experimental or Investigational; and
f. the most appropriate supply or Level of Care which can safely be provided. For Hospital stays this means the acute care as an Inpatient is necessary due to the type of Services a Member is receiving or the severity of the Member's condition and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Not all Medically Necessary and Appropriate services or supplies are covered. Please refer to the Medical Services and Hospital Services Sections of this Evidence of Coverage.

Us/We

Us and we refer to Physicians Health Services of New Jersey, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. 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.

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.

· 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 (877) 747-9585 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.

Penalties 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.

NOTES:

Summary of benefits for Physicians Health Services of New Jersey, Inc. - 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	13
Services provided by a hospital: • Inpatient	Nothing	23
• Outpatient	Nothing	24
Emergency benefits: • In-area	$10 per office visit; $25 per visit to urgent care center; $50 per visit to hospital emergency room	27
• Out-of-area	$10 per office visit; $25 per visit to urgent care center; $50 per visit to hospital emergency room	27
Mental health and substance abuse treatment	Regular cost sharing.	28
Prescription drugs	$10 for generic formulary drugs; $20 for preferred brand name drugs; $35 for all other drugs	30
Dental Care- (as described in Section 5(h)	Nothing	34
Vision Care	$10 per visit	18
Special features: Personal Health Advisor Interactive Provider Directory Disease State Management Programs Services for Deaf and Hearing Impaired		33
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,200/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	11

2001 Rate Information for
Physicians Health Services of New Jersey, Inc.

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.

Type of **Enrollment**	Code	***Non-Postal Premium***				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
		Gov't Share	Your Share	Gov't Share	Your Share	**USPS**	**Your**
						Share	Share
All of New Jersey							
High Option **Self Only**	**2F1**	**$72.92**	**$24.31**	**$158.00**	**$52.67**	**$86.29**	**$10.94**
High Option Self & Family	**2F2**	**$174.98**	**$58.32**	**$379.11**	**$126.37**	**$207.05**	**$26.25**