Presbyterian Health Plan

http://www.phs.org

PRESBYTERIAN Health Plan

2002

A Health Maintenance Organization

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

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

For changes in benefits see page 8.

This Plan has Commendable accreditation from NCQA. See the 2002 Guide for more information on accreditation

Enrollment codes for this Plan:

P21 Self Only
P22 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees Health Benefits Program

RI 73-563

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Introduction

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

This brochure describes the benefits of Presbyterian Health Plan under our contract (CS2627) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

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

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/356-2219 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Our Fee schedule is based on the Resource Base Relative Value Scale (RBRVS). The RBRVS method was designed by physicians to fairly compensate themselves based on (1) a nationally uniform relative value for service (2) geographic adjustment factor and (3) a nationally uniform conversion factor for service. This method has been adopted by our Federal Centers for Medicare and Medicaid Services for Medicare reimbursement.

The RBRVS pays higher for evaluation and management services and lower for procedures. All physicians receive reimbursement for both evaluation and management services and procedures. The effect upon the individual physician will vary depending upon how much time they spend in office-based services as compared to procedural-based services. Typically, physicians such as primary care physicians, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office-based services, and physicians such as surgeons, and cardiologists spend more time in procedure-based services. Although this fee schedule is both provider and health plan based, it results in a high quality health plan for you and your families.

Your Rights

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

- Presbyterian Health Plan is owned by Presbyterian Healthcare Services, which has been providing quality care for New Mexicans since 1908
- Presbyterian Health Plan has 15 years' experience in improving the health of individuals, families and communities
- Customer Satisfaction Measures
- Networks and Providers

If you want more information about us, call 800/356-2219 or write to Presbyterian Health Plan, PO Box 27489 Albuquerque, NM 87125-7489. You may also contact us by fax at 505/923-8163 or visit our website at www.phs.org.

Service Area

To enroll in this Plan, You must live or work in our Service Area. This is where our providers practice. Our service area is all counties of New Mexico, except for Otero County and southern Eddy County.

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

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

Section 2. How we change for 2002

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

Program-wide changes

- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (*Section 5(a).*

Changes to this Plan

- Your share of the non-Postal premium will increase by 11.2% for Self Only or 11.2% for Self and Family.
- We clarified that there is not an additional copay for a mammogram; the mammogram is included in the office visit copay.
- The benefit for all rehabilitative therapies of physical and occupational will decrease up to two months per condition. A $15 per visit copay applies.

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 1-800/356-2219.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We obtain, verify, review and evaluate practitioners' competencies and qualifications on an ongoing basis to determine whether they can participate as providers in our Plan. Providers we credential include Medical Doctors, Specialists, Physician Assistants, Certified Nurse Practitioners, Licensed Social Workers, and licensed Professional counselors.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. The listings are first organized by region within New Mexico – Central New Mexico, Northern New Mexico, and Southern New Mexico. Each region, physicians, other providers and facilities are organized by Physician directed Teams, Primary Care Physicians are listed as Family Practice, General Practice, Internal Medicine, Pediatrics and OB/GYN's acting as PCPs.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Your must select a primary care physician from the provider directory who is closest to home or work. Locations and telephone numbers of the participating doctors are listed in the provider directory or can be obtained by calling the member Services Department 505/923-5678 or 1-800/356-2219. By selecting a PCP who belongs to the plan, members are selecting their corresponding network of specialists, hospitals and other providers to serve their healthcare needs. A PCP selection form is in your packet. Select your provider by the 5-digit provider number and mail it in the return envelope.

- **Primary care**

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

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a woman's healthcare provider who has been credentialed by Presbyterian Health Plan to provide female-related care without a referral. Treatment for Infertility, Reproductive Endocrinology, and/or Gynecological Oncology may require pre-authorization. You do not need a referral from your PCP or Specialist for an evaluation from behavioral health services; however, you must call 505/923-5470 (Albuquerque area or 1-800/453-4347 (Outside Albuquerque) to access services.

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

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will issue a referral that will include the expiration date of the referral and the number of visits. If the consultant suggests additional services or visits, you must first check with your primary care doctor to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-356-2219 or 923-5678. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the 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 pre-authorization. Your physician must obtain pre-authorization for the following services: Durable Medical Equipment, Home Health, Hospice, Home IV/Infusion, Acute Rehabilitation, Outpatient Rehab, Ambulance, Skilled Nursing Facilities and Mental Health/Substance Abuse care.

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or for gynecological or maternity care, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining specialty services. Your physician must get our approval before sending you to a hospital. Referral to a participating specialist is given at the primary care doctor's discretion. If required medical services are not available from participating providers, the Primary Care Physician must request and obtain written authorization from the Presbyterian Health Plan Medical Director before the Member may receive 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, facility, pharmacy, etc., 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

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

Example: In our Plan, you pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

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

- Prescription drugs
- Dental services
- Vision Services

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

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 62 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-356-2219 or at our website at www.phs.org.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deducible.
- 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	$10 per office visit
• In an urgent care center	$10 in Service Area $15 out of Service Area
• During a hospital stay	Nothing
• In a skilled nursing facility*:* Admission must be arranged and preauthorized by the Plan. Skilled Nursing facility care is provided for up to 60 days per member, *per calendar year.*	Nothing
• For office medical consultations	$10 per office visit
• For second surgical opinion	$10 per office visit
At home	$10 per visit

Diagnostic and treatment services -- continued on next page

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

Preventive Care - Adult -- continued on next page

Preventive care, adult *(continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years	**You pay nothing for charges. Additional mammograms are covered when determined to be medically necessary by a participating provider.**
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Well-child care charges for routine examinations, immunizations and care (under age 22) • Examinations, such as: – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (under 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 33 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 per office visit up to a maximum of $100 per pregnancy
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*
Family planning	
A broad range of voluntary family planning services, limited to:	
• Voluntary sterilization	50% of all charges
• Surgically implanted contraceptives (such as Norplant)	50% of all charges-insertion $10 per visit-removal
• Injectable contraceptive drugs (such as Depo provera)	50% of all charges
• Intrauterine devices (IUDs)	50% of all charges
• Diaphragms	$10 per visit
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). **Note:** Devices are covered under 5 (a).	50% of all charges
NOTE: We cover oral contraceptives under the prescription drug benefit.	
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the medical benefits. Artificial insemination is covered up to 3 inseminations.	50% of all charges 50% of all charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
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	You pay
• Chemotherapy and radiation therapy **Note:** High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 29. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Growth Hormone is covered for children with growth potential who have total or partial growth hormone deficiency (idiopathic or organic). The diagnosis of growth hormone deficiency must be confirmed by at least two stimulation tests. Growth hormone injections are specifically excluded for Turner's syndrome or Down's syndrome, unless growth hormone deficiency can be documented, and when preauthorized by us. For adults, growth hormone is covered only for non-functioning or surgically removed pituitary glands with demonstrated low levels of growth hormone. Growth hormone injections are excluded for chronic renal failure or other chronic disease regardless of stimulated growth hormone levels. We will ask that your physician submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Continuation of therapy using any drug is dependent upon its demonstrable efficacy.	$10 per office visit Note: 10% of all charges for Recombinant DNA and Purified Biological Products.
Not covered:	*All charges.*

Physical and occupational therapies	You Pay
• Provided in-patient or out-patient up to 2 months per condition if significant improvement is expected for the services of each of the following: – qualified physical therapists; and – occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. In-patient or out-patient therapy may be extended 2 additional months if significant improvement is expected to continue and must be preauthorized by PHP This benefit is *not* renewable each calendar year. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 12 sessions with continuous electrocardiogram (ECG) monitoring or up to 24 sessions with intermittent ECG monitoring at an approved facility.	$15 per visit
Not covered: • *Long-term rehabilitative therapy* *(Any therapy beyond 6 months is defined as long term therapy.)* • *Exercise programs*	*All charges.*
Speech therapy	
Speech Therapy is covered for up to 2 months when provided by a licensed or certified speech therapist subject to the following: • Speech Therapy is medically necessary • Speech Therapy *must be* preauthorized by us. • Following the initial 2 months of treatment, in-patient or outpatient Speech Therapy may be extended for a period not to exceed 2 additional 2-month periods.	$15 per visit
Not covered: • *Speech Therapy beyond 6 consecutive months.*	*All charges*.

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (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)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	20% of all charges
• Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) Screening performed to determine the need for vision correction. This does not include routine eye exams or refractions performed by eye care specialists.	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthopedics* • *Radial keratotomy and other refractive surgery* • *Replacement of all items referenced in this section due to wear, loss, or damage*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per 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	You Pay
• Artificial limbs and eyes; stump hose • Orthotic appliances including braces and other external devises used to correct a body function. Benefits will be provided if medically necessary and preauthorized. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. *Note:* We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of tempormanibular joint (TMS) pain dysfunction syndrome. Prosthetics devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth necessitates replacement. For diabetics, covered services include foot appliances, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment. Penile Prosthesis is limited to the reasonable charge for semi-rigid or flexible rod prosthesis. Benefits for inflatable penile prosthesis may be provided when medically necessary. Prosthetic Devices will be provided when determined to be medically necessary by the plan physician. Prosthetic devices must be preauthorized by us.	20% of all charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered* • *speech synthesis devices*	*All charges.*

Durable medical equipment (DME)	You Pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs (non- motorized); • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	20% of all charges
Not covered: • *deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.* • *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. • Recombinant DNA and Purified Biological Products	Nothing 10% of all charges
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home Care primarily for personal assistance does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All charges.*

Chiropractic	You Pay
Chiropractic Services – 18 visits per year if medically necessary. Preauthorization is required. • Your plan physician must determine in consultation with us that your treatment will result in significant improvement in your condition within 2 months. • Following the initial evaluation and 6 sessions, inpatient or outpatient chiropractic treatment may be extended for a period not to exceed 2 additional 6-session periods when: – preauthorized by us, and – the plan physician certifies that the therapy is medically necessary and is resulting in significant improvement. The determination of significant improvement will be established if the member has met all therapy goals for the preceeding 6 sessions as documented on the therapy record. • Chiropractic treatment is specifically limited to treatment by means of manual manipulation, by the use of hands, and ultrasound therapy. • Subluxation must be documented by chiropractic examination and documented in the chiropractic records. • Chiropractic x-rays are only covered if preauthorized. Preauthorization for x-rays performed by a chiropractor will be considered for the following clinical situations, unless clinically relevant x-rays already exist: – Acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents – Clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over ½ inch, or spine curvature consistent with osteoporotic fractures; or – Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement.	$15 per office visit

Chiropractic -- continued on next page

Chiropractic *(continued)*	**You Pay**
Not covered: *Chiropractic treatment for chronic subluxation of rheumatoid arthritis, allergy muscular dystrophy, multiple sclerosis, pneumonia, or chronic lung disease, and other diseases/conditions.* *Diagnostic or therapeutic service furnished by a chiropractor including magnetherm, or any other mechanical form of treatment* *Rolfing* *Massage therapy* *Naturopathic services* *Hynotherapy* *Biofeedback*	*All charges.*
Alternative treatments	
Acupuncture/Meridian Therapy – 20 visits per year if determined medically necessary by a doctor of medicine or osteopathy, chiropractor or doctor of Oriental Medicine acting within the scope of his/her license for anesthesia or chronic or acute pain relief. Both a referral is required from your plan physician and preauthorization from us. Treatment of other medical conditions using acupuncture or meridian therapy will be covered only if the following conditions are met: • There is evidence-based medical literature that clearly supports the safety, efficacy and appropriateness of this treatment for the specific medical condition for which authorization is requested. • Acupuncture or meridian therapy must be part of a coordinated plan of care	$15 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	
Educational classes and programs	
No Benefit.	*All charges.*

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns	$10 per office visit – Outpatient Nothing – Inpatient

Surgical procedures *(continued)*	**You pay**
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.	
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	Nothing
• 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	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Pancreas islet cell infusion • 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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • National Transplant Program (NTP) – All organ transplants must be medically necessary. Transplants will be performed as a site approved by us. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. The plan will pay reasonable and customary charges for hospital, surgical, laboratory and x-ray services for a donor who is not entitled to benefits under any other health benefit plan or policy. Donor charges must result from the medically necessary covered transplant of an organ or body tissue to a member of the plan. Limited travel benefits are available for the transplant recipient and one other person. Transportation costs will be covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be covered for both out-of-state and in-state, up to a maximum of $150 a day for both combined. All benefits for transportation, lodging and meals are limited to a maximum of $10,000. All transplant benefits, including travel, are limited to a lifetime maximum of $500,000 (including immunosuppressive drugs).	$10 per visit – Outpatient Nothing – Inpatient

Organ/Tissue Transplants – continued on next page

Organ/tissue transplants *(Continued)*	**You pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Non-human organ transplants, except for porcine (pig) heart valves*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$10 per 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 Sections 5(a) or (b).
- Hospital Service must be preauthorized by us.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS**

IMPORTANT

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

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, 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	You Pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **NOTE**: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF): 60 days per member per calendar year Note: Room and board and other necessary services are provided when you require skilled nursing care of the type provided by the facility. Admission to the facility must be arranged by your Primary Care Physician or a physician to whom you are referred and must be preauthorized by Presbyterian Health Plan.	Nothing
Not covered: custodial care or domiciliary care	*All charges.*

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

Ambulance	You Pay
Local professional ambulance service when medically appropriate.	
• Ground Ambulance	$50 copay per occurrence
• Air Ambulance	$100 copay per occurrence

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

In determining whether you acted as a "reasonable layperson" we will determine the following factors:

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

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

No prior authorization is required for emergency care.

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

Emergencies within our service area:

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

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

Emergencies outside our service area:

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

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

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

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
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 enhanced mental health and substance abuse benefits you must follow your treatment plan and all the following authorization processes:

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

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A participating plan healthcare provider must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy, (except for out-of-area emergencies), or by mail for a maintenance medication. Mail order medications are available through the Mail Service Pharmacy identified in the Doctors and Facilities Directory. Order forms are available from the Plan's customer service department.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor. Prescription medications are prescribed by a Plan healthcare provider and dispensed in accordance with the Plan's drug formulary. The formulary is a list of generic and brand name medications that we selected to meet patient needs for quality treatment at a lower cost. You may request a copy of this formulary by calling Member Services at 1-800-356-2219 or 923-5678. An on-line version of our formulary is also available at our web site – www.phs.org (under Services & MDS-Pharmacy).

These are the dispensing limitations.

- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Member Service at 505-923-5678 or 1-800-356-2219. An on-line version of our formulary is available on our web site – www.phs.org (under Services and MDs – Pharmacy).
- Prescription medications prescribed by a Plan healthcare provider and obtained at a Plan pharmacy will be dispensed for up to a 30 day supply or 100-unit supply, whichever is less, or one commercially prepackaged unit i.e. one inhaler, one vial ophthalmic drops, one vial of insulin). Any amount of medication beyond these quantity limits, even if necessary to obtain a months supply, will be associated with multiple copays (for example 200 tablets of a medication or 2 prepackaged inhalers, necessary for a months supply, will be associated with payment of two copays for that medication).
- Maintenance formulary medications purchased through the mail order option will be for a 90-day supply or 300-units, whichever is less, or 3 commercially prepackaged units. Non-formulary medications are not available through the mail order option. If you or your healthcare provider request a brand name drug in place of the generic, you pay the difference in price between the brand and generic, plus the applicable generic copay.
- Brand name drugs will be associated with a brand copay, even if a generic equivalent is not available.
- Prescription refill requests through a Plan pharmacy or the mail order option will be processed at or near the expected time at which the original supply of medication would be exhausted. Requests for early refills can be made to the Plan pharmacy, who can then request approval from the Plan. Replacement prescriptions resulting from loss, theft, or destruction are not a covered benefit.
- **Why use geneic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your Plan less money that a name-brand drug.

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

In-Network

No claims filing is necessary. You are responsible for paying the copayment or coinsurance.

Out-of-Network

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

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

A separate claim form is required for each family member.

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

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

Mail proof to:

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

Benefit Description	You pay
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 those listed as *Not covered*. • Insulin, with a copay charge applied to each vial • Diabetic supplies, including insulin syringes, needles, blood test strips, urine test tape, and acetone test tablets. (Glucose monitors are covered as durable medical equipment, see under DME section) • All FDA-approved oral and injectable contraceptive drugs and contraceptive devices • Disposable needles and syringes for the administration of covered medication • Drugs for sexual dysfunction (see Prior authorization below) • Fertility drugs, oral or injectable, including those provided in a physician's office. • Injectable drugs or products (recombinant DNA & Purified Bilological Products)	$5 per generic – 30 day supply or 100 units whichever is less $15 per brand – 30 day supply or 100 units whichever is less **Mail order** $10 per generic – 90 day supply or 300 units whichever is less. $30 per brand – 90 day supply or 300 units whichever is less Note: If there is no generic equivalent available, you will still have to pay the brand name copay. 50% of all charges for Fertility Drugs 10% of all charges for DNA & Purified biological Products

Covered medications and supplies -- continued on next page

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 specifically Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements that can be purchased without a prescription* • *Replacement prescriptions resulting from loss, theft, or destruction* • *Drugs from which there is a nonprescription equivalent available* • *Medical supplies such as dressings and antiseptics* • *Smoking cessation drugs and medication, including nicotine patches* • *Nonprescription medicines*	*All charges.*

Section 5 (g). Special features

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

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered-services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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.	$10 per visit
Dental benefits (Limited)	
Limited dental services will be provided when preauthorized by us. Services include but are not limited to the following: • Accidental injury to sound natural teeth. • Oral surgery Medically Necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space. • Removal of infected teeth in preparation for certain surgeries or radiation therapy of the head and neck. **Temporomandibular Joint Disorders (TMJ)** The treatment of Temporomandibular Joint disorders (TMJ) are subject to the same conditions and limitations as are applicable to treatment of any other joint in the body. Orthodontics are not covered unless the TMJ disorder is the result of an injury.	$10 per visit

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

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

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

  The Dental Source Dental Plan features no deductibles, no claims forms, no waiting periods, no maximums, and no pre-existing condition exclusions. It is a comprehensive plan including preventive and diagnostic service restoratives, dentures, oral surgery, endodontists, periodontists, and orthodonics for adults and children. For additional information and customer service call 1-888-862-8659.

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

- A four week health education class on diabetes (including diet) is free to you and $23 for non-members. Preregistration is required. Call 505/823-8408.

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 11.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

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

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer -- such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:
Presbyterian Health Plan
PO Box 27489
Albuquerque, NM 87125-7489

Prescription drugs

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

Submit your claims to:
Presbyterian Health Plan
Attn: Pharmacy
PO Box 27489
Albuquerque, NM 87125-7489

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: PO Box 27489 Albuquerque, NM 87125-7489; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letter, 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 3, 1900 E Street, NW, Washington, DC 20415-3630.

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 include a copy of your specific written consent with the review request.

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

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

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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/356-2219 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice 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 (Part A or Part B)

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** 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 reemploy annuitant with the Federal government when…	✓	
a) The position is excluded from FEHB, or		
b) The position is not excluded from FEHB		✓
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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your 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 800/356-2219.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- 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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments, coinsurance, or deductibles. You must use our provider network to receive secondary benefits from us. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Custodial care

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

Experimental or investigational services

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

Medical necessity

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

Plan allowance

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

Us/We

Us and we refer to Presbyterian Health Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

•Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc

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

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long-term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half them will. And it's not just the old folks. About 40% of people needing long-term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long-term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100-day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long-term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

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

Summary of benefits for the Presbyterian Health Plan - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care	14
Services provided by a hospital: • Inpatient ..... • Outpatient.....	Nothing Nothing	31 33
Emergency benefits: • In-area ..... • Out-of-area	$25 outpatient hospital visit $15 urgent care center $10 doctor's office	38 38
Mental health and substance abuse treatment.....	Regular cost sharing.	39
Prescription drugs	$5 formulary generic $15 formulary brand name and non-formulary	41
Dental Care	Limited benefit. $10 per visit	46
Vision Care	20% of all charges (materials) $10 per office visit (eye exam for children).	21
Special Features: Flexible benefits option; Services for deaf and Hearing impaired, high risk pregnancies		45
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,000/Self Only or $4,000/Family enrollment per year Some costs do not count toward this protection	12

2002 Rate Information for
Presbyterian Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, 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 who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
All Counties of New Mexico, except for Otero and Southern Eddy County							
Self Only	P21	$81.34	$27.11	$ 176.24	$58.74	$96.25	$12.20
Self and Family	P22	$212.12	$70.71	$459.60	$153.20	$251.01	$31.82