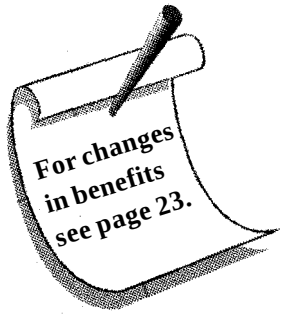
PHYSICIANS™
HEALTH•SERVICES

Physicians Health Services of Connecticut, Inc.

1999

A Health Maintenance Organization with a Point of Service Product



Serving: All of Connecticut

Enrollment Code:
DP1 Self Only
DP2 Self and Family

Enrollment in this Plan is limited; See page 8 for requirements.

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.phshmo.com

Authorized for distribution by the
United States Office of Personnel Management

Federal Employees Health Benefits Program
RI 73-140

Physicians Health Services of Connecticut, Inc.

Physicians Health Services of Connecticut, Inc., One Far Mill Crossing, Shelton, CT 06484-0944, has entered into a contract (CS 1960) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Physicians Health Services, or PHS or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 23 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits, or in order to increase the amount of FEHB benefits, is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800/441-5741 toll free and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E. Street NW, Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: (1) by the Plan and its subcontractors only for internal administration of the Plan, coordination of benefit provisions with other plans and subrogation of claims; (2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; (3) by OPM to review a disputed claim or perform its contract administration functions; (4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or (5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in your Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15, or when you self-refer for Point of Service, or POS, benefits as described on pages 18-19. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See *If you are hospitalized* on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member is confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also provide you with an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" on page 3. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you need to be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency or POS benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant or family member enrolled in one FEHB Plan is not entitled to receive benefits under any other FEHB Plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.
- Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.
- You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

- Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B.

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a 31-day free extension of coverage. The employee or family member may also be eligible for one of the following:

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Coverage from the last FEHB Plan to cover you. This certificate, along with other certificates you receive from other FEHB Plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Former spouse coverage

When the spouse of a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced, or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 % administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouses's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan—Information you have a right to know

This Plan is a comprehensive medical plan sometimes called a Health Maintenance Organization (HMO) that offers a Point of Service, or POS product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are encouraged to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts of comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See pages 18-19 for more information.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not because a particular provider is in the Plan's network. You can not change plans because a provider leaves the HMO.

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the carrier at 1-800-441-5741, or you may write to the carrier at PHS, One Far Mill Crossing, Shelton, CT 06484-0944. You may also contact the carrier by fax at (203) 381-6769, at its website at htpp://www.phshmo.com, or by e-mail at member@phshmo.com

Information that must be made available to you includes:

- Disenrollment dates for 1997
- Compliance with state and federal licensing or certification requirement and the dates met. If noncompliant, the reason for noncompliance
- Accreditation by recognized accrediting agencies and the dates received
- Carrier's type of corporate form and years in existence
- Whether carrier meets state, federal, and accreditation requirements for fiscal solvency, confidentiality, and transfer of medical records

Who provides care to Plan members?

PHS is an HMO which allows you to choose your own participating doctor and hospital. When you join, you can choose your personal doctor from among internists, pediatricians, general practitioners and family practitioners. There are over 10,000 doctors available to members throughout the service area. Members are requested to contact their primary care doctor at the first sign of illness. If specialty services are necessary, you may see a Plan specialist without a referral from your primary care doctor. The Plan provides emergency care 24 hours a day, seven days a week. This Plan also provides benefits for certain services under the POS product even when these services are provided by non-Plan doctors. Please review this brochure carefully so that you understand which benefits will be covered and what the level of coverage will be.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you for certain specialty care or making arrangements for hospitalization when using the standard HMO network. Under this Plan, you can obtain services from a specialist without a referral from your primary care doctor.

Choosing your doctor

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Relations Department at 1-800/441-5741. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency or POS benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

If you enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) selected for you and each member of your family. Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a Plan doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary, to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized or for certain procedures that require authorization. For out-of-network services, **you** must receive prior authorization (see page 18).

For new members

If you are already under the care of a primary care doctor or a specialist who is a Plan participant, when this Plan takes effect, your care will be covered by the Plan under standard in-network HMO benefits.

Hospital care

If you require hospitalization, for in-network care your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care. If you are admitted to a non-Plan hospital or are admitted to a Plan hospital by a non-Plan doctor **you** must obtain the necessary prior authorization (see page 18).

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $1,200 per Self Only enrollment or $3,000 per Self and Family enrollment for standard in-network HMO benefits. This copayment maximum does not include costs of prescription drugs or the cost of self- referral (out-of-network) deductibles and coinsurance. See page 18 for out-of-pocket maximums for self-referral (out-of-network) services.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for non-Plan emergency care claims, prescription drug claims, or self-referral/out-of-network claims (see pages 18 and 19) submitted 6 months after care was rendered, unless timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigative determinations

The Plan considers factors, such as: published reports and articles in the authoritative medical, scientific, and peer review literature; or written protocols used by the treating facility or being used by another facility studying substantially the same drug, device or medical treatment. The Plan also considers Federal and other government agency approval as essential to the treatment of an injury or illness by, but not limited to, the following: American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, the Food and Drug Administration, or the National Institutes of Health.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's Service Area

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live or work inside the service area or live in the geographic area described below.

Service Area: Services from Plan Providers are only available in the State of Connecticut.

Benefits for care outside the service area are limited to emergency services, as described on page 15, and to services covered under Point of Service Benefits, as described on pages 18 and 19.

If you or a covered family member move outside the Service Area or you no longer work there, you may enroll in another approved plan any time. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, or services covered under this Plans POS benefits, unless you use Plan Providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits for medical and hospital costs from, any other group health coverage, including no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care unless you use a non-plan provider for POS benefits as described on page 18. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

General Limitations *continued*

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers' Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the definitions, limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless, your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see *Emergency Benefits*) or for eligible self-referred services obtained under Point of Service Benefits (see pages 18 and 19).
- Expenses incurred while not covered by this Plan
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services and supplies related to sex transformations
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term

Medical and Surgical Benefits (In-Network)

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits (**You pay** a $10 office visit copay, except for well-baby visits and periodic check-ups through the age of 19; in addition, you do not pay any additional copay for laboratory tests, X-rays, maternity care, immunizations and non-allergy injections). Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate (**You pay** nothing for a doctor's visit, nothing for home visits by nurses and health aides).

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one baseline mammogram during these five years; for women age 40 years and older, one mammogram per calendar year. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females. Copays are waived for maternity care. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary, including prenatal, delivery and postnatal care by a Plan doctor. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of the infant requiring definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization; family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials such as bee venom extract and allergy serum (**you pay** a $10 copayment per visit)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Corneal, kidney, kidney-pancreas, liver and heart, heart/lung (single and double) transplants; 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; breast cancer; multiple myeloma; epithelial ovarian cancer; testicular, mediastinal, retroperitoneal, ovarian germ cell tumors; and advanced neuroblastoma. Transplants are covered when approved in advance by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. Immunosuppressives and transportation costs are not covered.
- Women who undergo masectomies may at their option have this procedure on an inpatient basis and remain in the hospital for up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Internal prosthetic devices
- Home health services of nurses and health aides, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers
- Naturopathy services are covered as an office visit only
- Acupuncture services are covered as an office visit only. Services must be approved in advance upon the request of the member's primary care physician, participating naturopath or chiropractor. Laboratory services associated with acupuncture services must be performed at a participating facility.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporo-mandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition which has resulted in a functional defect or which has resulted from accidental injury or surgery that has produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery.

Physical, speech and occupational therapy on an inpatient basis will be provided for up to two months per condition if significant improvement can be expected within two months. **You pay** nothing per session.

Physical therapy, occupational therapy, and chiropractic care on an outpatient basis will be provided for up to two months per condition if significant improvement can be expected within two months. **You pay** a $10 copayment per visit. If during the two month period, the member has not incurred 30 visits, the member will be entitled to the additional number of visits needed to reach the 30 visit limit, if significant improvement can be expected within these additional visits. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. No benefits will be paid other than the initial evaluation when services are not authorized by PHS or its designee.

Cardiac rehabilitation on an outpatient basis, when approved in advance by a Plan doctor, will be covered for up to two months per condition if significant improvement can be expected within two months. **You pay** a $10 copayment per visit. If during the two month period, the member has not incurred 30 visits, the member will be entitled to the additional number of visits needed to reach the 30 visit limit, if significant improvement can be expected within these additional visits.

Speech therapy on an outpatient basis will be provided for up to two months per condition if significant improvement can be expected within two months. **You pay** a $10 copayment per session. Speech therapy, provided on an inpatient or outpatient basis, is limited to treatment of certain speech impairments of organic origin.

Diagnosis and treatment of infertility is covered; **you pay** a $10 copay per visit. The following type of artificial insemination is covered: intrauterine insemination (IUI); **you pay** a $10 copay per visit; cost of donor sperm is not covered. Fertility drugs are covered under the Prescription Drug Benefit. Other **assisted reproductive technology (ART) procedures** that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization and embryo transfer are not covered.

Foot Orthotics, the Plan pays 50% of the doctor's charge up to a maximum payment by the Plan of $125 per member per calendar year.

Durable Medical Equipment, such as wheelchairs and hospital beds, and orthopedic devices, such as braces, are limited to the initial appliance or piece of equipment. The Plan will pay 50% of the cost up to a maximum of $500 per member per calendar year for the initial appliance or piece of equipment.

Outpatient oxygen—the Plan will pay up to a maximum of $300 per member per calendar year.

External prosthetic devices, such as artificial limbs, are limited to maximum payment by the Plan of $5,000 for the initial appliance and $500 per necessary replacement prosthetic. Diabetic equipment and supplies, including glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Homemaker services
- Long-term rehabilitative therapy
- Refractions, refractive eye surgery (radial keratotomy), including lens prescription
- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- Transplants not listed as covered
- Lenses following cataract removal
- Vision therapy, including othoptics and pleoptics training
- Naturopathy Services—Coverage excludes any non-legend drugs, herbs or medications dispensed by the naturopath.
- Acupuncture Services—Coverage excludes any non-legend drugs, herbs or medications dispensed by the acupuncturist. Laboratory services associated with acupuncture services must be performed at a participating provider for coverage to be afforded.

Hospital/Extended Care Benefits (In-Network)

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. **All necessary services are covered,** including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits up to 60 days each calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. **All necessary services are covered,** including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical Substance Abuse Benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

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 the Plan may determine are medical emergencies—what they all have in common is the need for quick action.

Emergencies within the Service Area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (*e.g.*, the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan**must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

In-network benefits are available for care from non-Plan providers in a medical emergency**only** if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Plan pays...

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

You pay...

A $10 copay per doctor's visit or urgent care center visit; a $50 copay per hospital emergency room visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Emergencies outside the Service Area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized in a non-Plan facility, the Plan**must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan any follow-up care recommended by non-Plan providers must be approved by the Plan, or by Plan providers except as covered under POS benefits.

Plan pays...

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

You pay...

A $10 copay per doctor's office or urgent care center visit; a $50 copay per emergency room visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service if approved by the Plan

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area

Filing claims for non-Plan providers

In certain circumstances, with your authorization, the Plan will pay emergency benefits directly to the providers of your emergency care upon receipt of their claims, submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and a PHS out-of-network claim questionnaire. Claims must be submitted within six months of the date services were rendered. In the Plan's judgment, if there are extenuating circumstances, the Plan will pay claims beyond the six-month deadline. A payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. You may request reconsideration in accordance with the disputed claims procedure set forth on page 21.

Mental Conditions/Substance Abuse Benefits (In-Network)

Mental conditions

The Plan provides coverage for the following biologically-based mental illnesses to the same extent as any other medical condition: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder (autism).

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute non-biologically-based psychiatric conditions, including treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to a maximum of 30 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; prior authorization is required for all visits in excess of the sixth visit to determine the medical necessity for future visits. The number of visits that may be eligible for coverage is determined by PHS and must be medically necessary under generally accepted standards; **you pay** a $20 copay per visit for each covered visit.

Inpatient care

Inpatient treatment of biologically-based mental conditions requires prior authorization by PHS. Non-biologically-based mental conditions are covered for up to 60 days of hospitalization each calendar year; **you pay** nothing for first 60 days. The services must be prior authorized and be performed at a PHS-approved facility or at a PHS-designated Center of Excellence.

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Marriage counseling, psychiatric and other treatment for sexual dysfunction and sex therapy

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and, to the extent shown below, the services necessary for diagnosis and treatment. Prior authorization is required for all substance abuse treatment.

Outpatient care

Up to 45 days per calendar year, or, at the discretion of PHS, an equivalent outpatient program of 45 days or more may be substituted. **You pay** a $10 copay per visit for each covered visit. The outpatient days are a part of the inpatient care benefit. Each day used under the outpatient benefit reduces the coverage available under the inpatient benefit on a one-for-one basis.

Inpatient care

Up to 45 days per calendar year in a substance abuse rehabilitation center is covered for the treatment of substance abuse. **You pay** nothing during the benefit period. The 45 days in a substance abuse rehabilitation center are part of the 45 day outpatient program benefit described above. Each day used under the inpatient benefit reduces the days of coverage available under the outpatient benefit on a one-for-one basis.

What is not covered

- Treatment that is not authorized by a Plan doctor; treatment that is not prior authorized by PHS; treatment not received at a PHS-approved facility or at a PHS-designated Center of Excellence.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day maximum. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. **You pay** a $10 copayment per prescription unit or refill.

- If a member requests and obtains a brand-name drug when a generic equivalent is available, the member will be responsible to pay the difference between the brand-name and generic equivalent.

The Plan uses a formulary that includes generic and preferred brand name drugs. The Plan's Pharmacy and Therapeutics Committee meets on a quarterly basis to review new medications to be added to or deleted from the formulary. Review for additions to the formulary are based primarily on the following: 1) new drug therapies introduced, 2) changes in drug therapies, and 3) requests received from participating physicians. The criteria used are the safety and efficacy of the drug, other similar products available, and its relative cost. Deletions are decided by the committee based on low utilization, other types of equivalent therapy, or negative changes in existing drug therapies. Your doctor can ask for exceptions to the formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin
- Disposable needles and syringes needed to inject covered prescribed medication
- Intravenous fluids and medications for home use (covered under Medical and Surgical Benefits as a home health service, see page 11)
- Oral and injectable contraceptives and contraceptive devices including implanted contraceptive devices, such as Norplant
- Fertility drugs
- Immunosuppressive drugs

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Prescription drugs obtained for use in connection with drug addiction
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches

Point of Service Benefits

Members may use non-participating doctors for most services covered under the Plan. For eligible POS services, the **Plan pays** 80% of usual, customary and reasonable (UCR) charges after you pay a $300 deductible per Self Only enrollment or $750 per Self and Family enrollment. **You pay** the deductible once per calendar year and 20% of UCR thereafter. If the charge is more than the UCR, you must also pay the difference. There is an out-of-pocket maximum of $1,200 per Self Only enrollment and $3,000 per Self and Family enrollment for self-referral services.

Benefits under the POS option are also subject to the definitions, limitations, and exclusions shown elsewhere in this brochure. The Plan determines the medical necessity of services and supplies provided to prevent, diagnose or treat an illness or condition. For any services that have a maximum benefit payment or visit limit, the services you receive out-of-network and the services you receive in-network will count cumulatively towards the limit.

There is a $1,000,000 lifetime maximum per person for POS services.

POS benefits are available for certain services. However, you should remember that the highest benefit available is provided through the standard in-network HMO benefit.

Prior Authorization of Hospital Inpatient Admissions

You must complete the prior authorization process before an elective admission to a nonparticipating hospital or when you are admitted to a Plan hospital by a nonparticipating doctor. If you do not complete the precertification process, a penalty of 50% of the cost of the case per each unauthorized occurrence will be deducted from the Plan's payment. You must complete the prior authorization process at least fourteen (14) business days in advance of an elective admission or two (2) business days in advance for diagnostic/urgent procedures.

Precertification of Elective Ambulatory Procedures or Diagnostic Procedures

You must complete the prior authorization process fourteen (14) business days in advance of an elective ambulatory surgical procedure or a penalty of the lesser of $500 or 50% of the cost of the case per each unauthorized occurrence will be deducted from the Plan's payment for the services rendered. You must complete the prior authorization process two (2) business days in advance of elective diagnostic procedures, or a penalty of 50% of the cost of the case per each unauthorized occurrence will be deducted from the Plan's payment for the services rendered.

A list of services requiring prior authorization is available to you from the Plan and is updated from time to time by the Plan. With regard to services that require prior authorization; such prior authorization must be obtained from PHS even in cases where PHS is the secondary payer.

Medical and surgical benefits (Point of Service)

What is covered

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "what is not covered". You pay 20% of UCR after the deductible is met.

- Physician office, home or hospital visits
- Specialist care and consultation
- Maternity care
- Diagnostic procedures, including laboratory and X-ray tests (prior authorization is required if services are performed in a nonparticipating hospital or facility or by a non-Plan doctor)
- Surgical procedures (prior authorization is required if services are performed in a nonparticipating hospital or facility or by a non-Plan doctor)
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials such as bee venom extract and allergy serum
- Non experimental implants (covered in full)
- Organ transplants (prior authorization is required); must be performed at a PHS-approved facility or at a PHS-designated Center of Excellence.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity (prior authorization is required)
- Foot orthotics (Plan pays 50% of charges or UCR, whichever is less, up to a maximum of $125 per member per calendar year)
- Internal prosthetic devices (covered in full)
- External prosthetic devices, such as artificial limbs, limited to a maximum benefit payment by the Plan of $5,000 for the initial appliance and $500 per necessary replacement prosthetic after you meet the deductible

- Naturopathy services—office visits
- Acupuncture services—office visits with approval in advance
- Home health services
- Durable medical equipment, such as wheelchairs and hospital beds, and orthopedic devices, such as braces, are limited to the initial appliance or piece of equipment. The Plan will pay 50% of the cost up to a maximum of $500 per member per calendar year for the initial appliance or piece of equipment after you meet the deductible.
- Outpatient oxygen—the Plan will pay up to a maximum of $300 per member per calendar year

What is not eligible for POS

The following services are available in-network only and must be provided by Plan doctors. You cannot self-refer to non-Plan doctors for these services.

- Preventive care, including well baby care and periodic checkups
- Routine immunizations and boosters
- Routine gynecological services

Hospital/extended care benefits

What is covered

At your option, you can choose to be admitted as an inpatient in a non-Plan hospital, hospice, or extended care facility through self-referral. You may also choose to be admitted by a non-Plan doctor to a Plan hospital. In any event, **YOU MUST** notify the Plan in accordance with the prior authorization requirements on page 18 and the admission must be prior authorized by the Plan. If you do not obtain prior authorization, benefits will be reduced by 50% of the cost of the case. **You pay** 20% of UCR and any charges above the allowable amount after the deductible is satisfied. Ambulance charges are covered in full.

Emergency Care

What is covered

Any eligible services obtained from non-Plan providers and that are not considered to be a medical emergency will be treated as a self-referral/POS service and subject to deductible and 20% coinsurance for covered charges.

Mental conditions

What is covered

You can choose to receive the following services from non-plan physicians or providers or at non-plan facilities: Approval in advance is required for all visits in excess of the sixth visit to determine the medical necessity for future visits. The number of visits that may be eligible for coverage is determined by PHS and must be medically necessary under generally accepted standards.

- The Plan provides coverage for the following biologically-based mental conditions to the same extent as any other medical condition: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder (autism).
- Outpatient care for non-biologically-based mental conditions. **You pay** 50% of UCR after enrollee meets deductible (subject to the limitations shown on p. 16)
- Inpatient care. **You pay** 20% of UCR after enrollee meets deductible (subject to the limitations shown on p. 16)

What is not covered

- Refer to page 16.

Each visit or day used under the POS benefit reduces coverage available under the in-network benefit and vice versa.

Substance abuse

What is covered

You can choose to receive the following services from non-plan physicians or providers or at non-plan facilities. Approval in advance is required for all substance abuse services.

- Outpatient care. **You pay** 50% of UCR after enrollee meets deductible (subject to the limitations shown on p. 16)
- Inpatient care. **You pay** 20% of UCR after enrollee meets deductible (subject to the limitations shown on p. 16)

What is not covered

- Refer to page 16.

Each visit or day used under the POS benefit reduces coverage available under the in-network benefit and vice versa.

Other benefits

What is covered

Prescriptions written as a result of a self referral to a doctor are eligible for coverage as long as they meet all other requirements for drugs to be covered. The prescription must be filled at a participating pharmacy. **You pay** a $10 copayment per prescription unit or refill (subject to the limitations on p. 17).

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum, copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

Physicians Health Services

Survival School isn't really a school at all. It's simply a way to help you figure out how to live healthier. Without creating a lot of guilt. Without hardship. Without doing without. All with the understanding that being healthy means more than just staying alive.

We're all drowning in information about diets and the like. But the most important information about what's good for your body comes from your body. When your stomach is full. When your knees ache. When you feel great in the morning. Your body talks to you all the time. Survival School simply helps you learn how to listen.

* **Special discounts and pricing at fitness and weight management organizations...**This way, working out your arms and legs doesn't cost you an arm and a leg.

* **Free and Clear...**A smoking cessation program that is available at a discount to all PHS members. With the help of your PHS doctor, you set up your own date to stop smoking.

* **First Steps**[SM]**...**is about helping newborns and their parents get off on the right foot. You can choose gift options that provide advice on infant care for first-time parents and information about raising a baby, or that help you keep track of important events such as immunizations and doctor visits. It's a special program for a special time.

* **LegWork...**is a walking program that is more than just a way to exercise your heart, lungs and legs. It's a way to slow down and take in the interesting things we miss everyday. Walking puts your nose at flower-smelling level. LegWork is a go-at-your-own-pace exercise program that you control.

For more information about any of our Survival School programs, simply give us a call at 1-800/441-5741. Or, write us at Physicians Health Services of Connecticut, One Far Mill Crossing, Shelton, CT 06484-0944.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Relations Department at 1-888/747-1747 or you may write to them at One Far Mill Crossing, Shelton, CT 06484-0944. You may also contact the Plan through its website at http://www.phshmo.com; fax at (203) 381-6769, or e-mail at member@phshmo.com

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing, within one year of the denial, to reconsider its denial before you request a review by OPM. OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan should state why you believe the denied claim for payment or service should have been paid or provided. Refer to specific benefit provisions in this brochure.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information, it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative and request an OPM review on your behalf and with your written consent. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review should state whey you believe the Plan should have paid the denied claim. Refer to specific benefit provisions in this brochure. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (If the Plan failed to respond, provide instead (a) the date of your request to the Plan, or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, Explanation of Benefit forms, etc.); and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Retirement and Insurance Service, Office of Insurance Programs, Insurance Contracts Division IV, P.O. Box 436, Washington, DC 20044.

No lawsuit may be brought to recover on a claim for this Plan's benefits until either you or, in the case of an assigned claim, your provider has exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management.

Federal law exclusively governs all claims of relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How Physicians Health Services of CT, Inc. Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide changes

- Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- If you have a chronic, complex or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment Plan with you and your health plan that allows an adequate number of direct access visits with that specialist without the need to obtain further referrals (see page 7 for details).

A medical emergency is defined as a sudden and unexpected onset of a condition or injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care (see page 15).

- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under the Plan's Mental Conditions Benefit.

Plan changes

- Biologically-based mental illnesses are covered to the same extent as other medical conditions; non-biologically-based mental conditions are subject to the specified limits.
- Mammography screening is covered once per calendar year for women 40 years of age or older.
- Diabetic supplies and equipment are covered.

Summary of Benefits for Physicians Health Services of CT, Inc. — 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED AS IN-NETWORK BENEFITS UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN THEY ARE PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of **medical** and **surgical** services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. In-Network Benefit: **You pay** nothing	14
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	14
	Extended Care	All necessary services, up to 60 days per calendar year when in lieu of hospital care. In-Network Benefit: **You pay** nothing	14
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	14
	Mental Conditions	Diagnosis and treatment of biologically-based mental conditions. In-Network Benefit: **You pay** nothing	16
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	16
		Diagnosis and treatment of acute non-biologically-based psychiatric conditions for up to 60 days of inpatient care per year. In-Network Benefit: **You pay** nothing	16
		Out-of-Network Benefit: You pay 20% of UCR after deductible	16
	Substance Abuse	Up to 45 days per year (each day used under the inpatient benefit reduces days of coverage available under the outpatient substance abuse benefit on a one-for-one basis). In-Network Benefit: **You pay** nothing	16
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. In-Network Benefit: **You pay** $10 copay per office visit, nothing for house calls by a doctor	11
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible per office visit or for house calls by a doctor	11
	Home Health Care	All necessary visits by nurses and health aides. In-Network Benefit: **You pay** nothing	11
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	11
	Mental Conditions	Biologically-based mental conditions. In Network Benefit: **You pay** $10	16
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	16
		Non-biologically-based mental illness up to 30 outpatient visits per year. In-Network Benefit: **You pay** $20 copay per outpatient visit	16
		Out-of-Network Benefit: **You pay** 50% of UCR after deductible	16
	Substance Abuse	Up to 45 days per year (each day used under the outpatient benefit reduces days of coverage available under the inpatient substance abuse benefit on a one-for-one basis). In-Network Benefit: **You pay** $10 copay per visit	16
		Out-of-Network Benefit: **You pay** 20% of UCR after deductible	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $10 copay per doctor's office or urgent care visit; a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	15
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a participating pharmacy. **You pay** a $10 copayment per prescription unit or refill	17
Dental care		No current benefit	
Vision care		No current benefit	
Out-of-pocket limit		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,200 per Self Only or $3,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs or the cost of self-referral deductibles and coinsurance. See pages 18 and 19 for out-of-pocket maximums for self-referred services	8

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1999 Rate Information for Physicians Health Services of Connecticut, Inc.

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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
Self Only	DP1	$72.06	$40.60	$156.13	$87.97	$84.98	$27.68
Self and Family	DP2	$160.39	$154.45	$347.51	$334.64	$183.29	$131.55