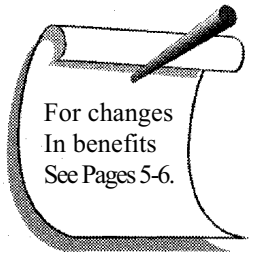
PHYSICIANS™
HEALTH■SERVICES

Physicians Health Services of Connecticut, Inc. 2000

A Health Maintenance Organization



Serving: All of Connecticut

Enrollment Code:
DP1 Self Only
DP2 Self and Family

Enrollment in this Plan is limited; See page 22 for requirements.

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

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United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-140

Physicians Health Services of Connecticut, Inc.

Table of Contents

Introduction

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

This brochure describes the benefits you can receive from Physicians Health Services (PHS) under its contract CS1960 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 11. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to PHS as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How To Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

You will not have to submit claim forms or pay bills. However, when you receive services you must pay the copayments listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How We Change For 2000

To keep your premium as low as possible, OPM has set a minimum of $10 for all primary care office visits.

Program-Wide Changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, *How to get benefits,* for more information).

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes To This Plan

- Your share of the non-postal standard option premium will decrease by 17.7% for self only or 10.9% for self and family.
- Discontinue Point of Service (POS) benefits.
- Except in an **emergency**, all medical care, including hospitalization, must be provided by a PHS Plan physician or provider and when appropriate, prior authorized by the PHS Medical Director.
- **Foot Orthotics** are not covered
- **Oxygen and related respiratory** equipment no longer have a dollar limit.

- **Durable Medical Equipment (DME)** is limited to $1,500 per member per calendar year.
- **Nutritional counseling** when provided by a Plan provider for the treatment of metabolic disorders and lipid abnormalities to a maximum of three (3) visits per calendar year (except for the treatment of diabetes).
- **Speech therapy** requires prior approval. Speech therapy is limited to organic causes and a 90 day treatment period.
- **Cardiac rehabilitation** as part of an approved cardiac rehabilitation program, for a maximum of twelve (12) weeks following a myocardial infarction or cardiac surgery.
- **Chiropractic care** on an outpatient basis will be provided for up to two (2) months per condition if significant improvement can be expected within two (2) months. You pay a $10 copayment per visit. If during the two (2) month period the member has not incurred thirty (30) visits, the member will be entitled to the additional number of visits needed to reach the thirty (30) visit limit, if significant improvement can be expected within these additional visits.
- **Diagnosis and treatment of infertility** is covered; you pay a $10 copayment per visit. The following type of artificial insemination is covered; intrauterine insemination (IUI); The cost of donor sperm is not covered. Fertility drugs are covered under the Prescription Drug Benefit.
- **Acupuncture,** when prior authorized by PHS up to twenty (20) visits per member per calendar year. The copayment is $20 per visit.
- **Vision Therapy services** (orthoptic and/or pleoptic therapy) are covered to a maximum of three (3) visits per member per calendar year. This is not intended to exclude coverage for medically necessary and appropriate treatment for diseases of the eye.
- **Routine Eye Examinations**: One (1) routine eye examination including an eye refraction per calendar year for members to the attainment of nineteen (19) years of age; One (1) routine eye examination including an eye refraction every two (2) calendar years for members nineteen (19) years of age and older.
- **Diabetic equipment and supplies** are now covered.
- **Rehabilitative and restorative physical, occupational, speech, respiratory therapy and skilled nursing** care is limited to a combined maximum of ninety (90) days per calendar year, when prior authorization is obtained from PHS and when services are performed in a Plan Inpatient facility. Up to 60 days may be used for Inpatient Rehabilitation (physical, occupational, speech, respiratory therapy.)
- The prescription benefit has changed to a three tier copayment option. Refer to page 17 for specifics.

Section 3. How To Get Benefits

To enroll with us, you must live or work in our service area. Our service area is: the state of Connecticut.

What Is This Plan's Service Area

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. We will not pay for any other health care services such as elective care or non-emergency care outside the service area.

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

How Much Do I Pay For Services?

You must share the cost of some services. This is called a copayment (a set dollar amount). For most medical services the copayment is $10.00 per office visit. Please remember you must pay this amount when you receive services. After you pay $1,200 in copayments for one family member, or $3,000 per family, you do not have to make any further payments for certain services for the rest of the year. This is called catastrophic limit. However, copayments for your prescription drugs do not count toward these limits and you must continue to make these payments.

Be sure to keep accurate records of your copayments.

Do I Have To Submit Claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who Provides My Health Care?

All medical care, including hospitalization, must be provided by a PHS Plan physician or provider and when appropriate, Prior Authorized by the PHS Medical Director. A woman may see her obstetrician/gynecologist directly without a referral from her primary care physician for one well woman examination per year.

What Do I Do If My Primary Care Physician Leaves The Plan?

Call us. We will help you select a new one.

What Do I Do If I Need To Go Into The Hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What Do I Do If I'm In The Hospital When I Join This Plan?

First, call our customer service department at (877) 747-9585. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How Do I Get Specialty Care?

Although, you are not required to do so, you are encouraged to rely on your primary care physician to coordinate your medical care.

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

What Do I Do If I Am Seeing A Specialist When I Enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What Do I Do If My 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.

But, What If I Have A Serious Illness And My Provider Leaves The Plan Or This Plan Leaves The Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How Do You Authorize Medical Services?

Your physician is responsible for obtaining prior authorization before sending you to a hospital, referring you to a Non-plan specialist, or for some medical services. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How Do You Decide If A Service Is Experimental Or Investigational?

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

- The service or supply has not been formally approved by, or cannot be lawfully marketed without the approval of the appropriate government regulatory body or agency, including, but not limited to, the U.S. Food and Drug Administration, and, at the time it is furnished, such approval has not been given; or

- The written informed consent form to be used by the treating facility or by other facilities in studying substantially the same service or supply, refers to such service or supply as Experimental or Investigational, or as a research project, a study, an investigation, a test, a trial, or words of similar effect; or
- The written informed consent form and/or the written protocols to be utilized by the treating facility for specific services or supplies has not been reviewed and/or has not been approved by the treating facility's Institutional Review Board, or other body serving a similar function, or if federal law requires such review and approval; or
- The informed consent documents and/or the written protocols and/or published reports or peer review articles in authoritative medical and scientific literature show that the service or supply is the subject of a protocol(s) or study, including Phase I, II, or III clinical trial study, or is otherwise under study to determine any of the following: its maximum tolerated toxicity, its safety, its efficacy, or its overall benefits and risks as compared with a standard means of treatment or diagnosis.

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

Section 4. What To Do If We Deny Your Claim or Request For Service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:
1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:
1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When May I Ask OPM To Review A Denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service? Call us (877) 747-9585 and we will expedite our review.

What If You Have Denied My Request For Care And My Condition Is Serious Or Life Threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division IV at (202) 606-0737 between 8 a.m. and 5 p.m. Serious or life threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are There Other Time Limits

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What Do I Send To OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who Can Make The Request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where Should I Mail My Disputed Claim To OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division IV, P.O. Box 436, Washington, D.C. 20044.

What If OPM Upholds The Plan's Denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What Laws Apply If I File A Lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

Section 4. What To Do If We Deny Your Claim or Request For Service *continued*

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your Records And The Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

- A comprehensive range of preventive, diagnostic and treatment services is provided by Plan physicians and other Plan providers. This includes all necessary office visits (You pay a $10 office visit copayment, except for well-baby visits and periodic check-ups through the age of 19; In addition, you do not pay any additional copayments for laboratory tests, X-rays, maternity care, immunizations and non-allergy injections). Within the Service Area, house calls will be provided if in the judgement of the Plan physician such care is necessary and appropriate. (You pay nothing for a physician's home 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 39, one baseline mammogram during these 5 years; for women age 40 years and older, 1 mammogram per calendar year. In addition to routine screening, mammograms are covered when prescribed by the physician 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 of all covered females. Copayments 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 cesarean delivery. Inpatient stays will be extended if medically necessary, including prenatal, delivery and postnatal care by a Plan physician. 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**
- **Oxygen and related respiratory** equipment when prior authorized by PHS.

Care Must Be Provided Or Arranged By Plan Physicians.

- **Nutritional counseling** when provided by a Plan provider for the treatment of metabolic disorders and lipid abnormalities to a maximum of three (3) visits per calendar year (except for the treatment of diabetes).
- **Allergy testing** and treatment, including bee venom extract and allergy serum
- **Internal prosthetic devices** and the insertion of prosthetic devises, such as pacemakers and artificial joints
- **External prosthetic devices,** such as artificial limbs, are limited to a maximum payment by the Plan of $5,000 for the initial appliance and $500 per necessary replacement prosthetic.
- **External breast prostheses and surgical bras**
- **Corneal, kidney, kidney –pancreas, liver and heart, heart/lung, (single and double transplants; allogeneic (donor) bone marrow transplants; autologous stem cell and peripheral stem cell support) for the following conditions; acute lymphocytic or non-lymphocyticleukemia; advanced non Hodgkin's lymphoma; breast cancer; multiple myeloma; epithelial ovarian cancer; testicular, mediastinal, retroperitonea, 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. Immunosuppressive drugs (unless covered by a Rider) and transportation costs are not covered.
- Women who undergo **mastectomies** may at their option have this procedure on an inpatient basis and remain in the hospital for up to 48 hours after the procedure.
- Services directly related **to hemodialysis or peritoneal dialysis** for treatment of renal disease including equipment training and medical supplies, when arranged by a Plan physician, until the Member is eligible for the Medicare program
- **Chemotherapy, radiation therapy and inhalation therapy**
- **Surgical treatment of morbid obesity**
- **Home health services** of nurses and health aides, when prescribed by your Plan physician, who will periodically review the program for continuing appropriateness and need
- **All necessary medical and surgical** care in a hospital or extended care facility from Plan physicians and other Plan providers
- **Naturopathy services**
- **Acupuncture services** are covered when approved in advance up to 20 visits per member per calendar year. You pay a $20 copayment.

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
- Foot Orthotics
- Refractive eye surgery (radial keratotomy), including lens prescription

Care Must Be Provided Or Arranged By Plan Physicians.

- Corrective eyeglasses and frames or contact lenses (including fitting of the lenses)
- Transplants not listed as covered
- Non-legend drugs, herbs or medications dispensed by a naturopath or acupuncturist.

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 and 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 temporomandibuler 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 if condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Speech Therapy is covered to treat speech impairments or loss of organic origin and as the result of conditions such as injury, stroke or tumor removal, for a maximum period of ninety (90) consecutive days from the beginning of therapy with prior approval from the PHS Medical Director. You pay a $10 copayment per visit.

Chiropractic care on an outpatient basis will be provided for up to two (2) months per condition if significant improvement can be expected within two (2) months. You pay a $10 copayment per visit. If during the two (2) month period the member has not incurred thirty (30) visits, the member will be entitled to the additional number of visits needed to reach the thirty (30) visit limit, if significant improvement can be expected within these additional visits.

Rehabilitative and restorative physical, occupational, speech, respiratory therapy and skilled nursing care is limited to a combined maximum of ninety (90) days per calendar year when prior authorization is obtained from PHS and when services are performed in a plan inpatient facility. Up to 60 days may be used for inpatient rehabilitation (physical, occupational speech, resporatory therapy.)

Cardiac rehabilitation on an outpatient basis, as part of an approved cardiac rehabilitation program for a maximum of twelve weeks following a myocardial infarction or cardiac surgery. You pay a $10 copayment per session.

Diagnosis and treatment of infertility is covered; you pay a $10 copayment per visit. The following type of artificial insemination is covered; intrauterine insemination (IUI); The 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.

Care Must Be Provided Or Arranged By Plan Physicians.

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 $1500 per member per calendar year for the initial appliance or piece of equipment.
Vision Therapy Services (orthoptic and/or pleoptic therapy) are covered to a maximum of three (3) visits per member per calendar year. This is not intended to exclude coverage for medically necessary and appropriate treatment for diseases of the eye.
Nutritional counseling when provided by a Plan provider for the treatment of metabolic disorders and lipid abnormalities to a maximum of three visits per member per calendar year (except for the treatment of diabetes).

Hospital/Extended Services

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

What Is Covered

Hospital Care

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

Extended Care

Rehabilitative and restorative, physical, occupational, speech, respiratory therapy and skilled nursing care is limited to a combined maximum of ninety (90) days per calendar year, when prior authorization is obtained from PHS and when services are performed in a Plan inpatient facility. Up to 60 days may be used for inpatient rehabilitation (physical, occuational, speech respiratory therapy). You pay nothing for:

- 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 physician.

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 physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance Services

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

Limited benefits

Inpatient Dental Procedures

Hospitalization for certain dental procedures is covered when a Plan physician 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 of 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 physician determines that outpatient management is not medically appropriate. See page 17 for Non-Medical Substance Abuse benefits.

Care Must Be Provided Or Arranged By Plan Physicians.

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 physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified. If you need to be hospitalized in a Non-Plan facility, the Plan must be notified with in 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.

Benefits are available for care from Non-Plan providers in a medical emergency only if delay in reaching 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…

$50 per emergency room visit or $10 copay per doctor's office or urgent care center visit for emergency care services that are covered benefits by 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 an injury or unforseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in Non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. To be covered by this Plan any follow-up care recommended by Non-Plan providers must be approved by the Plan or Plan providers. If you are hospitalized in Non-Plan facilities and Plan physicians believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Care Must Be Provided Or Arranged By Plan Physicians.

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

Plan Pays…

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

You Pay…

You pay a $10 copayment per physician 's office visit; urgent care or walk-in center and a $50 copayment per visit to a hospital emergency room. If the emergency results in an admission to a hospital, the emergency copayment is waived.

What Is Covered

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

What Is Not Covered

- Elective or non-emergency 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

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be 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 the identification information from your ID card.

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. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 10.

Mental Conditions

The Plan provides coverage for the following biologically –based mental illnesses to the same extent as any other medical conditions: 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 physicians, consultants or other psychiatric personnel each calendar year; prior authorization is required for all visits in excess of the 6th visit to determine the medical necessity for

Care Must Be Provided Or Arranged By Plan Providers.

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 copayment per each covered visit.

Inpatient Care

Inpatient treatment of any mental condition requires prior authorization by PHS. Non-biologically based mental conditions are covered to a maximum of 60 days per calendar year. Biologically–based mental conditions are covered to the same extent as any other medical conditions.

What Is Not Covered

- Care for psychiatric conditions, which in the professional judgement of Plan physicians 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 physician to be medically 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

The 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 copayment 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 for the treatment of substance abuse in a substance abuse rehabilitation center. You pay nothing during the benefit period. The 45 days in a substance abuse rehabilitation center are part of the 45 outpatient program described above. Each day used under the inpatient benefit reduces the number of days eligible for coverage under the outpatient benefit on a one-for-one basis.

What Is Not Covered

Treatment that is not authorized by a Plan physician, treatment that is not prior authorized by PHS and is 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 for generic formulary drugs, $20 for preferred brand name, and $35 for all others. The cost of prescriptions filled through the Plan's mail order supplier will be equal to 2 copayments for a 90 day supply.

Care Must Be Provided Or Arranged By Plan Physicians.

The Plan uses a formulary that includes generic and preferred name brand drugs. The Plan's Pharmacy and Therapeutics Committee meets on a quarterly basis to review new medications to be added to or deleted from the formulary.

Reviewers for additions to the formulary are based primarily on the following.
1. New drug therapies introduced.
2. Changes in existing drug therapies, and
3. Requests received from 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 available, or negative changes in existing drug therapies. You doctor can ask for exceptions to the formulary. Nonformulary drugs will be covered when prescribed by a Plan doctor.

Members may obtain maintenance prescription medications through a mail service pharmacy benefit. Maintenance medications are drugs used on a continual basis for the treatment of chronic health conditions, such as high blood pressure, ulcers or diabetes. To participate in the program, contact the Plan.

Covered medications and accessories include:
- Drugs for which a prescription is required by law
- Oral contraceptive and injectable contraceptives and contraceptive devices including implanted contraceptive devices, such as Norplant
- Insulin
- Diabetic equipment and supplies, including glucose test tablets and test tape, Benedict's solution or equivalent, acetone test tablets, insulin pumps and appurtenances, infusion devices, blood glucose monitors, and additional diabetes equipment and supplies as listed by the Department of Health.
- Disposable needles and syringes needed to inject covered prescribed medication.
- Intravenous fluids and medication for home use, implantable drugs, are covered under Medical and Surgical Benefits. See page 12.
- Growth hormones
- Fertility drugs

What Is Not Covered

- Drugs available without a prescription or for which there is a non prescription 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 medications including nicotine patches.

Care Must Be Provided Or Arranged By Plan Physicians.

Other Benefits

Dental Care

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. **You pay** nothing.

Accidental Injury Benefit

What Is Not Covered

- Other dental services not shown as covered.

Vision Care

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, the following benefits are provided:

What Is Covered

Routine Eye Examinations: One (1) routine eye examination including an eye refraction per calendar year for members to the attainment of nineteen (19) years of age; One (1) routine eye examination including an eye refraction every two (2) calendar years for members nineteen (19) years of age and older.

What Is Not Covered

- Corrective lenses or frames
- Eye exercises

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, and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are subject to the FEHB disputed claims procedure.

The PHS "Healthy Extras" Program

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

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

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

- **Personal Health Advisor℠ Line:** Talk with a registered nurse — 24 hours a day, seven days a week — to get answers to your health questions.

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

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

- **Chronic-Disease Care Programs:** For those facing the challenges of diabetes, congestive heart disease, asthma, glaucoma, osteoporosis, kidney disease and other chronic conditions, PHS offers education and care-management programs to help members better manage their conditions.

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

- **Interactive Voice Response Program:** When you need to locate a participating physician but don't have access to the PHS printed directory or to the Internet, just call (800) 686-9847 toll-free, enter a zip code, and a list of local physicians will be mailed or faxed to you.

PHS *Smart*Choice Medicare+Choice Program

Medicare beneficiaries have the opportunity to enroll in the PHS *Smart*Choice Medicare+Choice plan. If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. (For details, see page 20 inside this brochure.) PHS has more than a decade of experience with Medicare-approved health plans.

We are committed to providing members with high quality, easily accessible and affordable health care coverage with unsurpassed customer service. If you are interested in enrolling in PHS *Smart*Choice, please call (800) 747-1823 toll-free for more information.

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 physician determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

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

Section 7. Limitations — Rules That Affect Your Benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833).

Other Group Insurance Coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

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

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

Circumstances Beyond Our Control

Under certain extraordinary circumstances, we may have to delay your services or be unable to provide them. In that case, we will make all reasonable efforts to provide you with necessary care.

When Others Are Responsible For Injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

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

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB Facts

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 877-747-9585, or write to One Far Mill Crossing, Shelton, CT 06484-0944. You may also contact us by fax at 203-381-6769, or visit our website at www.phshmo.com.

Where Do I Get Information About Enrolling In The FEHB Program?

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
- The next Open Season for enrollment.

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.

When Are My Benefits And Premiums Effective?

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

What Happens When I 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, which is described later in this section.

What Types Of Coverage Are Available For My Family And Me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are My Medical And Claims Records 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 benefits 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.

Information For New Members

Identification Cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What If I Paid A Deductible Under My Old Plan?

Your old plan's deductible continues until our coverage begins.

Pre-Existing Conditions

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

When You Lose Benefits

What Happens If My Enrollment In This Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What Is Former Spouse 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 more information about your coverage choices.

What Is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How Do I Enroll In TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How Can I Convert To Individual Coverage?

You may convert to an 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 if individual coverage is available. 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.

How Can I Get A Certificate Of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 877-747-9585 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202-418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Physicians Health Services of CT, Inc. — 2000

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 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. **You pay** nothing	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
	Mental Conditions	Diagnosis and treatment of biologically-based mental conditions. **You pay** nothing	16
		Diagnosis and treatment of acute non-biologically-based psychiatric conditions for up to 60 days of inpatient care per year. **You pay** nothing	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). **You pay** nothing	17
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. **You pay** $10 copay per office visit, nothing for house calls by a doctor.	11
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	14
	Mental Conditions	Biologically-based mental conditions. **You pay** $10	16
		Non-biologically-based mental illness up to 30 outpatient visits per year. **You pay** $20 copay per outpatient visit.	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). **You pay** $10 copay per visit.	17
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 for generic formulary drugs; $20 for preferred brand name; and $35 for all others.	17
Dental care		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. **You pay** nothing.	
Vision care		In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, the following benefits are provided: Routine Eye Examinations: One (1) routine eye examination including an eye refraction per calendar year for members to the attainment of nineteen (19) years of age; One (1) routine eye examination including an eye refraction every two (2) calendar years for members nineteen (19) years of age and older.	
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.	7

2000 Rate Information For
Physicians Health Services of Connecticut

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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
All of Connecticut									
Self Only	**DP1**	**$ 78.83**	**$ 33.40**	**$170.80**	**$ 72.37**	**$ 93.06**	**$ 19.17**	**$ 93.26**	**$ 18.97**
Self and Family	**DP2**	**$175.97**	**$137.67**	**$381.27**	**$298.28**	**$207.74**	**$105.90**	**$201.02**	**$112.62**