

Presbyterian Health Plan

www.phs.org

Customer Service: 800-356-2219



2023

A Health Maintenance Organization (High, Standard and Wellness Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 12 for details.

Serving: *All counties of New Mexico*

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment codes for this Plan:

High Option

- P21 Self Only
- P23 Self Plus One
- P22 Self and Family

Standard Option

- PS4 Self Only
- PS6 Self Plus One
- PS5 Self and Family

Wellness Option

- PS1 Self Only
- PS3 Self Plus One
- PS2 Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2023: Page 14
- Summary of Benefits: Page 99



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United States
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Healthcare and Insurance
<http://www.opm.gov/insure>

RI 73-563

**Important Notice from Presbyterian Health Plan About
Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that Presbyterian Health Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.

Call 800-MEDICARE (1-800-633-4227), (TTY 877-486-2048).

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Introduction

This brochure describes the benefits of Presbyterian Health Plan under contract (CS 2627) between Federal Employees Health Benefit and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The Presbyterian Customer Service Center can be reached at 800-356-2219 or through our website: www.phs.org/fehb. The address for Presbyterian Health Plan's administrative offices is:

Presbyterian Health Plan
9521 San Mateo, NE
Albuquerque, NM 87113

Or

P.O. Box 27489
Albuquerque, NM 87125-7489

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2023, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2023, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples.

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

Stop Healthcare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except to your healthcare providers, authorized health benefit plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statement that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 505-923-5678 or toll-free 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Presbyterian Health Plan complies with applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management

Healthcare and Insurance

Federal Employee Insurance Operations

Attention: Assistant Director, FEIO

1900 E Street NW, Suite 3400-S

Washington, D.C. 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosages that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, or through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"

Ask your surgeon:

- "Exactly what will you be doing?"
- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For information on patient safety, please visit

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events if you use Presbyterian preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

No pre-existing condition limitation

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

Minimum essential coverage (MEC)

Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

Minimum value standard

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/healthcare-insurance for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies that participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, give you other plan's brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next Open Season for enrollment begins.

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc. you must also contact your employing or retirement office.

Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

• Types of coverage available for you and your family

Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family member. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to add a family member when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a family member if you currently have a Self Only plan.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB Plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB Plan.

If you have a qualifying event (QLE), such as marriage, divorce, or birth of a child, outside of the Federal Benefits Open Season you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children

Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance

Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2023 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2022 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee, Tribal employee, or an annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's Website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

We also want to inform you that the Patient Protection and ACA did not eliminate TCC or change the TCC rules.

Converting to individual coverage

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

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-356-2219 or visit our website at www.phs.org.

Health Insurance Marketplace

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provide up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Presbyterian Health Plan holds the following accreditations: NCQA and/or the local plans and vendors that support Presbyterian Health Plan hold accreditation from NCQA. To learn more about this plan's accreditation(s), please visit the following websites: www.phs.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

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

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

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

General features of our High, Standard, and Wellness Options

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Our Fee Schedule is based on the Resource Base Relative Value Scale (RBRVS). The RBRVS method was designed by physicians to fairly compensate themselves based on:

1. a nationally uniform relative value for service;
2. geographic adjustment factor; and
3. a nationally uniform conversion factor for service.

This method has been adopted by our Federal Centers for Medicare and Medicaid Services for Medicare reimbursement.

The RBRVS pays higher for evaluation and management services and lower for procedures. All physicians receive reimbursement for both evaluation and management services and procedures. The effect upon the individual physician will vary depending upon how much time they spend in office-based services as compared to procedural-based services.

Typically, providers such as primary care physicians, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office-based services, and providers such as surgeons, and cardiologists spend more time in procedure-based services. Although this fee schedule is both provider and health plan based, it results in a high quality health plan for you and your families.

Your Rights and responsibilities

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

- Presbyterian Health Plan (a for profit organization) is owned by Presbyterian Healthcare Services (a non-profit organization), which has been providing quality care for New Mexicans since 1908.
- As part of Presbyterian Healthcare Services, the health plan represents an organization with over 100 years of community service to New Mexicans.
- Customer Satisfaction Measures
- Networks and Providers
- 111 Years in existence

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.phs.org. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-356-2219, or write to Presbyterian Health Plan, P.O. Box 27489, Albuquerque, NM 87125-7489. For the hearing impaired, call our TTY line at 711 or toll-free 800-659-8331. You may also visit our Website at www.phs.org/fehb.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.phs.org/fehb to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area includes all counties of New Mexico.

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. 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. Full-Time dependent students attending school outside Presbyterian Health Plan's service area can receive care at a Student Health Center without a preauthorization from their Primary Care Physician. Services provided outside of the Student Health Center are for medically necessary services for the initial care or treatment of an Emergency or Urgent Care situation.

Section 2. Changes for 2023

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

Program-wide Changes

Changes to High Option:

- Your share of the premium rate will increase for Self Only or increase for Self and Family. See page 105
- Tier 2 - Preferred drugs cost share increased to \$75 from \$50 copay per 30-day supply. See page 69
- Special Medical Foods– The Plan will decrease the cost share to 30% coinsurance with no age limitation from 50% of the Plan allowance, with no age limitation. See page 73
- Iatrogenic infertility preservation – The Plan will cover iatrogenic infertility at 30% coinsurance. See Page 31-32

Changes for Standard Option:

- Your share of the premium rate will increase for Self Only or increase for Self and Family. See page 105
- Special Medical Foods– The Plan will decrease the cost share to 30% coinsurance with no age limitation from 50% of the Plan allowance, with no age limitation. See page 73
- Iatrogenic infertility preservation – The Plan will cover iatrogenic infertility at 30% coinsurance. See Page 31-32

Wellness Option

- Your share of the premium rate will increase for Self Only or increase for Self and Family. See page 105
- Special Medical Foods– The Plan will decrease the cost share to 30% coinsurance with no age limitation from 50% of the Plan allowance, with no age limitation. See page 73
- Iatrogenic infertility preservation – The Plan will cover iatrogenic infertility at 30% coinsurance. See Page 31-32

Section 3. How You Get Care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 505-923-5678 or 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331. You may write to us at P.O. Box 27489, Albuquerque, NM 87125 You may also request replacement cards through our Website: www.phs.org/fehb.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

• Plan providers

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We obtain, verify, review, and evaluate practitioners’ competencies and qualifications on an ongoing basis to determine whether they can participate as providers in our Plan. Providers we credential include medical doctors, specialists, physician assistants, certified nurse practitioners, licensed social workers, and licensed professional counselors.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Website at www.phs.org/fehb. The listings are first organized by region within New Mexico – Central New Mexico, Northern New Mexico, and Southern New Mexico. Each region, physicians, other providers, and facilities are organized by primary care physicians are listed as family practice, general practice, internal medicine, pediatrics, and OB/GYN’s acting as PCPs.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, notational origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-356-2219 or through our website: www.phs.org/febh for assistance.

• Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Website: www.phs.org/doctors-services/Pages/find-a-doctor.aspx. Presbyterian Health Plan’s provider directory has a section that lists all participating facilities, hospitals, and pharmacies across the state.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must select a primary care physician from the PHP provider directory. Locations and phone numbers of the participating doctors are listed in the PHP provider directory or can be obtained by calling the Presbyterian Customer Service Center at 505-923-5678 or 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331 or by accessing our website at www.phs.org/fehb. By selecting a PCP who belongs to the plan, members are selecting their corresponding network of specialists, hospitals, and other providers to serve their healthcare needs.

• **Primary care**

Your primary care physician can be a family practice, general practice, internal medicine, pediatrics, and OB/GYN (if applicable) acting as a primary care physician. Your primary care physician will provide most of your healthcare or give you a referral to see a specialist.

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

• **Specialty care**

- Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. 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.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause;
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or

- reduce our service area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

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

- **If you are hospitalized when your enrollment begins** We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Center immediately at 800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 711 or 800-659-8331. If you are new to the FEHB Program, we will arrange for you to receive and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission** **Precertification** is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services** Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for services such as, but not limited to: Durable Medical Equipment, Hospice, Acute Rehabilitation, Outpatient Rehab, Skilled Nursing Facilities, Hospitalization and Mental Health/Substance Use Disorder care.

Except in medical emergency you must obtain pre-authorization prior to seeing a non-Plan physician. Your Plan physician must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan physician must request and obtain written authorization from the Presbyterian Health Plan Medical Director before you may receive services.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative must call us at 800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 711 or 800-659-8331 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

• Non-urgent care claims

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

• Urgent care claims

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us toll-free at 800-356-2219. For the hearing impaired, call our TTY line at 711 or toll-free at 800-659-8331. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us toll-free at 800-356-2219. For the hearing impaired, call our TTY line at 711 or toll-free at 800-659-8331. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.
- Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a caesarean section, then you, your representative, your physician or the hospital must contact us on precertification of additional days. Further, if your baby stays after you are discharged, your representative, your physician or the hospital must contact us for precertification of additional days for your baby.
- If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Certain services require approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for services such as, but not limited to: Durable Medical Equipment, Hospice, Acute Rehabilitation, Outpatient Rehab, Skilled Nursing Facilities, Hospitalization and Mental Health/Substance Use Disorder care.

Except in a medical emergency you must obtain pre-authorization prior to seeing a non-Plan physician. Your Plan physician must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan physician must request and obtain written authorization from the Presbyterian Health Plan Medical Director before you may receive services.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-356-2219.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	<p>A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.</p> <p>Example: High option, when you see your primary care physician for non-preventive services, you pay a copay of \$25 per office visit, and when you go see a specialist, you pay a copay of \$40 per office visit. When you see your primary care physician for preventive services, you pay nothing for the office visit and when you go see a specialist, you pay a copay of \$40 for adult and \$20 for children per office visit. When you go in the hospital, you pay \$100 copay per day up to 5 days per admission.</p>
Deductible	<p>A deductible is a fixed expense you must incur for certain covered services and supplies before the plan starts paying benefits. Copays do not count toward any deductible.</p> <ul style="list-style-type: none">• This High Option HMO plan does not have a deductible.• The calendar year deductible is \$500 per person under the Standard Option and \$2,000 under the Wellness Option plan. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach \$500 under Standard Option and \$2,000 under the Wellness Option plan. Under a Self Plus One or Self and Family enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach \$1,000 under the Standard Option and \$4,000 under the Wellness Option. <p>Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.</p> <p>If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.</p>
Coinsurance	<p>Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.</p> <p>Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment</p>
Differences between our Plan allowance and the bill	You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	<p>After your (copays and coinsurance) total \$6,350 for self only or \$12,700 for Self Plus One or Self and Family enrollment under the High and Standard Options and \$8,150 for self only or \$16,300 for Self Plus One or Self and Family enrollment for the Wellness Option in any Calendar year, You do not have to pay any more for Covered services. However, copays and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copays and/or coinsurance for these services:</p> <ul style="list-style-type: none">• Dental services• Vision services• Non-covered charges

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

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to see reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating healthcare provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care - when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

In addition, your health plan adopts and complies with the surprise billing laws of New Mexico under the New Mexico Surprise Billing Protection Act (59A-57A, NMSA 1978) and the No Surprises Act.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.phs.org or contact the health plan at 800-356-2219.

• The Federal Flexible Spending Account Program - FSAFEDS

- **Healthcare FSA (HCFSA)** - Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you, your tax dependents, and your adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High, Standard and Wellness Options Benefits Overview

See page 14 for how benefits changed this year. Page 97-101 is a benefits summary of the High, Standard and Wellness options. Make sure you review the benefits that are available in which you are enrolled.

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Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 per Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay		
	High Option	Standard Option	Wellness Option
Diagnostic and treatment services			
Professional services of physicians			
<ul style="list-style-type: none"> • Primary Care Physician 	\$25 copay per visit \$0 copay per visit for children up to age 26 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	\$30 copay per visit (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations) No deductible	First 4 visits: \$20 copay, not subject to deductible Subsequent visits: 30% coinsurance, subject to deductible
<ul style="list-style-type: none"> • Specialist 	\$40 copay per visit to specialist \$20 copay per visit to specialist for children up to age 26	\$40 copay per visit (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations) No deductible	\$40 copay, not subject to deductible Foot Care <ul style="list-style-type: none"> • First 2 visits: \$30 copay, not subject to deductible • Subsequent visits: 30% coinsurance, subject to deductible

Diagnostic and treatment services - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Diagnostic and treatment services (cont.)	High Option	Standard Option	Wellness Option
	(Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)		

Diagnostic and treatment services - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Diagnostic and treatment services (cont.)	High Option	Standard Option	Wellness Option
Applied Behavioral Analysis (ABA) Diagnosis and Treatment for all children up to age 26	\$0 copay per visit	\$0 copay per visit No deductible	30% coinsurance Subject to deductible
Telehealth services	High Option	Standard Option	Wellness Option
Telehealth (Video) visits An alternative access point for members to receive care for non-urgent medical issues such as upper respiratory infections, flu, cold, cough, and allergies. To access video visits you may visit the website at www.phs.org/videovisits .	\$0 copay per visit	\$0 copay per visit No deductible	\$0 copay No deductible
Lab, X-ray and other diagnostic tests	High Option	Standard Option	Wellness Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG 	Diagnostic tests are not subject to a copay regardless of whether an office visit is billed	Diagnostic tests are not subject to a copay regardless of whether an office visit is billed	First two diagnostic lab or x-ray have \$0 copay, no deductible 30% coinsurance deductible applies for visits thereafter
Computed Axial Tomography (CAT) scans/ Magnetic Resonance Imaging (MRI) tests/ Positron Emission Topography (PET) scans	\$100 copay per test	\$50 copay per test No deductible	30% coinsurance Subject to deductible
Sleep Studies- Outpatient overnight stay without admission	\$100 copay per test	\$50 copay per test No deductible	30% coinsurance Subject to deductible
Sleep Studies-Outpatient overnight stay with admission	\$100/day copay per admission up to 5 days	30% coinsurance per admission Deductible applies	30% coinsurance Subject to deductible

High, Standard and Wellness Options

Benefit Description	You pay		
Preventive care, adult	High Option	Standard Option	Wellness Option
<p>Routine physical every year.</p> <p>The following preventive services are covered at the time interval recommended at each of the links below.</p> <ul style="list-style-type: none"> • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://www.healthcare.gov/myhealthfinder 	Nothing	Nothing No deductible	Nothing No deductible
Routine mammogram - covered:	Nothing	Nothing No deductible	Nothing No deductible
<p>Adult immunizations, endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.</p> <p>healthfinder.gov/myhealthfinder/default.aspx</p>	Nothing	Nothing No deductible	Nothing No deductible
Preventive Vision Exam - One exam per year	\$0 copay when using Presbyterian Vision Plan Network Provider www.davisvision.com	Not covered, you pay all charges	Not covered, you pay all charges

Preventive care, adult - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Preventive care, adult (cont.)	High Option	Standard Option	Wellness Option
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copays, coinsurance, and deductible.			
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org 	Nothing	Nothing No deductible	Nothing No deductible
Preventive Vision Exam - One exam per year up to age 26	\$0 copay when using Presbyterian Vision Plan Network Provider www.davisvision.com	Not covered, you pay all charges	Not covered, you pay all charges
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copays, coinsurance, and deductible.			

Preventive care, children - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Preventive care, children (cont.)	High Option	Standard Option	Wellness Option
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools, camp or athletic exams or travel.</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Maternity care	High Option	Standard Option	Wellness Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Screening for gestational diabetes • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Surgical services are covered under Section 5(b) and Hospital services are covered under Section 5(c). <p>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p>	<p>\$25 copay per visit up to a maximum of \$150 per pregnancy</p> <p>Specialists (Perinatologist) - \$40 copay per visit to specialist</p> <p>Delivery - Inpatient - \$100/day copay per admission up to 5 days (included in inpatient hospital/ facility inpatient admission copay)</p>	<p>\$30 copay per visit up to a maximum of \$300 per pregnancy - No deductible</p> <p>Specialists (Perinatologist) - \$40 copay per visit - No deductible</p> <p>Delivery – Inpatient - 30% coinsurance/ \$2,000 Max per admission, Deductible applies</p>	<ul style="list-style-type: none"> • \$0 for routine prenatal care or for the first postpartum care visit; \$40 per office visit for all postpartum care visits thereafter • 0% coinsurance subject to deductible for delivery services
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing No deductible	Nothing No deductible
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

Maternity care - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Infertility services (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> - Ovarian stimulation, retrieval of eggs - Oocyte cryo-preservation <p>Note: Refer to our web site www.phs.org/fehb for more information regarding coverage and exclusion criteria</p>	30% of plan allowance	30% of plan allowance	30% of plan allowance

Infertility services - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Infertility services (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization (IVF)</i> - <i>Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Allergy care	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$25 copay per visit to primary care physician</p> <p>\$0 copay for children up to age 26 for participating providers</p> <p>\$40 copay per visit to specialist</p> <p>\$20 copay per visit to specialist for children up to age 26</p> <p>Allergy injections are included in the office visit copay. If there is no office visit, allergy injections are not subject to a copay.</p> <p>(waived if nursing visit only)</p>	<p>\$30 copay per visit to primary care physician</p> <p>\$40 copay per visit to specialist</p> <p>Allergy injections are included in the office visit copay. If there is no office visit, allergy injections are not subject to a copay.</p> <p>(waived if nursing visit only)</p> <p>No deductible</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<ul style="list-style-type: none"> • Allergy serum 	Nothing	<p>Nothing</p> <p>No deductible</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

High, Standard and Wellness Options

Benefit Description	You pay		
Treatment therapies	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 43.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided for up to 12 sessions. • Dialysis - hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Medical Drugs - All drugs and routes of administration provided or administered in an outpatient setting. • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See <i>Other services under You need prior Plan approval for certain services</i> on page 82.</p>	<p>\$25 copay per visit to primary care physician</p> <p>\$0 copay per visit to primary care physician for children up to age 26</p> <p>\$40 copayment per visit specialist</p> <p>50% of plan allowance up to a maximum of \$400 per prescription</p>	<p>\$30 copay per visit to primary care physician</p> <p>50% of plan allowance up to a maximum of \$400 per prescription</p>	<p>30% coinsurance, Subject to deductible</p> <p>Associated medications, 50% of the plan allowance up to a maximum of \$400 per prescription</p>

High, Standard and Wellness Options

Benefit Description	You pay		
Physical and occupational therapies	High Option	Standard Option	Wellness Option
<p>Provided in patient or out-patient up to 2 months per condition if significant improvement is expected for the services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists <p>Note: We only cover therapy when a provider orders the care. In-patient or out-patient therapy may be extended 2 additional months if significant improvement is expected to continue and must be preauthorized by PHP. Autism Spectrum Disorders are not subject to these limitations for children up to age 22.</p> <p>Note: We only cover therapy when a physician:</p> <ul style="list-style-type: none"> • Orders the care • Identifies the specific professional skills the patient requires and medical necessity for skilled services; and • Indicates the length of time the services are needed <p>Significant improvement means:</p> <ul style="list-style-type: none"> • The patient is likely to meet all therapy goals for the first two months of therapy; or • The patient has met all therapy goals in the preceding two months of therapy, as specifically documented in the therapy record. 	<p>\$25 copay per visit</p> <p>\$0 copay per office visit for children up to age 26</p> <p>Nothing per visit during covered inpatient admission</p>	<p>\$30 copay per visit</p> <p>No deductible</p> <p>Nothing per visit during covered inpatient admission</p>	<p>First 60 visits per condition: \$20 copay, Not subject to deductible</p> <p>Subsequent visits 30% coinsurance, Subject to deductible</p> <p>Nothing per visit during covered inpatient admission</p>
<p>Cardiac rehabilitation following qualifying event/condition is provided for up to 12 sessions with continuous electrocardiogram (ECG) monitoring and up to 24 sessions with intermittent ECG monitoring at an approved facility.</p>	<p>\$40 copay per visit</p> <p>\$20 copay per office visit for children up to age 26</p>	<p>\$40 copay per visit</p> <p>No deductible</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<p>Habilitative Therapy</p>	<p>\$40 copayment per visit</p> <p>\$20 copayment per office visit for children up to age 26</p>	<p>\$40 copay per visit</p> <p>No deductible</p>	<p>30% coinsurance, Subject to deductible</p>

Physical and occupational therapies - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Physical and occupational therapies (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> · Long-term rehabilitative therapy · Exercise programs 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Speech therapies	High Option	Standard Option	Wellness Option
<p>Speech Therapy is covered for up to 2 months when provided by a licensed or certified speech therapist subject to the following:</p> <ul style="list-style-type: none"> • Speech Therapy is medically necessary • Speech Therapy <i>must be</i> preauthorized by us • Following the initial 2 months of treatment, in-patient or outpatient Speech Therapy may be extended for a period not to exceed 2 additional 2-month periods. Autism Spectrum Disorder is not subject to these limitations for children up to age 26. 	<p>\$25 copay per visit</p> <p>\$0 copay per office visit for children up to age 26</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>\$25 adult copay per visit</p> <p>\$0 child copay per visit</p> <p>Not subject to deductible</p> <p>Nothing per visit during covered inpatient admission.</p>	<p>First 60 visits per condition: \$20 copay, Not subject to deductible</p> <p>Subsequent visits: 30% coinsurance, Subject to deductible</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <p><i>Speech Therapy beyond 6 consecutive months.</i></p>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by and M.D., D.O., or audiologist <p>Note: For routine hearing screening performed during a child's preventive care visit see Section 5(a) <i>Preventive care, children</i></p>	<p>\$15 copay per visit to primary care physician</p> <p>\$25 copay per visit to specialist</p>	<p>\$15 copay per visit to primary care physician</p> <p>\$25 copay per visit to specialist</p> <p>No deductible</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<ul style="list-style-type: none"> • Hearing testing for children through age 26 (<i>See Preventive care, children</i>) 	<p>\$0 copay per visit to primary care physician</p> <p>\$25 copay per visit to specialist</p>	<p>\$0 copay per visit to primary care physician</p> <p>\$25 copay per visit to specialist</p> <p>No deductible</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<ul style="list-style-type: none"> • Hearing aids (for children under age 18 or 21 years of age if still attending high school). We limit coverage up to \$2,200 every 36 months "per hearing impaired ear". 	<p>30% of the plan allowance</p>	<p>30% of the plan allowance</p> <p>No deductible</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing aids batteries 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

Hearing services (testing, treatment, and supplies) - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Hearing services (testing, treatment, and supplies) (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • <i>Hearing aids, except for children under age 18 or under 21 if still attending high school</i> • <i>Testing and examinations for hearing aids</i> • <i>Hearing services that are not shown as covered</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option	Wellness Option
Preventive Vision Exam - One exam per year	\$0 copay When using Presbyterian Vision Plan Network Provider www.davisvision.com	Not covered You pay all charges	Not covered You pay all charges
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see Preventive care, children) • One Eye refraction per year for children under 6 when medically necessary to aid in the diagnosis of certain eye diseases 	\$0 copay per visit to primary care physician \$20 copay per visit to specialist	\$0 copay per visit to primary care physician \$20 copay per visit to specialist No deductible	30% coinsurance Subject to deductible
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	30% of plan allowance	50% of plan allowance	30% coinsurance Subject to deductible
<ul style="list-style-type: none"> • Medically necessary service - disease or injury to the eye 	\$25 copay per visit to primary care physician \$40 copay per visit to specialist	\$30 copay per visit to primary care physician \$40 copay per visit to specialist No deductible	30% coinsurance Subject to deductible

Vision services (testing, treatment, and supplies) - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Vision services (testing, treatment, and supplies) (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 26</i> • <i>Eye exam for Standard Option</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Replacement of all items referenced in this section due to loss, neglect, theft, misuse, abuse or for convenience.</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Foot care	High Option	Standard Option	Wellness Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>\$25 copay per visit to primary care physician</p> <p>\$40 copay per visit to specialist</p>	<p>\$30 copay per visit to primary care physician</p> <p>\$40 copay per visit to specialist</p> <p>No deductible</p>	<p>First 2 visits: \$30 copay, Not subject to deductible</p> <p>Subsequent visits: 30% coinsurance, Subject to deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Orthopedic and prosthetic devices	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. 	30% of plan allowance	30% of plan allowance	30% coinsurance Subject to deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option	Wellness Option
<p>Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.</p>	30% of plan allowance	30% of plan allowance	30% coinsurance Subject to deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <p><i>Prosthetic replacements provided less than 3 years after the last one we covered</i></p>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option	Wellness Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps <p>Note: Call us at 800-356-2219 or 505-923-567 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	30% of plan allowance	50% of plan allowance	30% coinsurance Subject to deductible

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.</i> • <i>Repair and replacement due to loss, neglect, theft, misuse, abuse, to improve appearance or for convenience. Also repair and replacement of items under the manufacturer or supplier's warranty. If the Member has a functional wheelchair, regardless of the original purchaser of the wheelchair, additional wheelchair(s) are not Covered. One-month rental of a wheelchair is Covered if a Member owned wheelchair is being repaired.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Home health services	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>	<p>Nothing No deductible</p>	<p>30% coinsurance Subject to deductible</p>
<ul style="list-style-type: none"> • Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or caregiver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. Most Specialty Pharmaceuticals require Prior Authorization and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than \$600 for a 30-day supply. • Specialty Pharmaceuticals are not available through the mail order option and are limited to a 30-day supply. Some Specialty Pharmaceuticals may have additional day supply limitations. • The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. 	<p><i>50% of plan allowance up to a maximum of \$400 per prescription</i></p>	<p><i>50% of plan allowance up to a maximum of \$400 per prescription</i></p>	<p>50% coinsurance up to \$400 per prescription</p>

Home health services - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Home health services (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Chiropractic	High Option	Standard Option	Wellness Option
<p>Chiropractic Services - 30 visits per year if medically necessary.</p> <ul style="list-style-type: none"> • Your Plan physician must determine that your treatment will result in significant improvement in your condition • Chiropractic treatment is specifically limited to treatment by means of manual manipulation, by the use of hands, and ultrasound therapy • Subluxation must be documented by chiropractic examination and documented in the chiropractic records • Chiropractic X-rays are only covered when performed by a chiropractor for the following clinical situations, unless clinically relevant X-rays already exist: <ul style="list-style-type: none"> - Acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents - Clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over ½ inch, or spine curvature consistent with osteoporotic fractures; or - Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>\$30 copay per office visit - Adult</p> <ul style="list-style-type: none"> • 30 visits per year if determined medically necessary <p>\$20 copay per office visit - Children up to age 26</p> <ul style="list-style-type: none"> • 20 visits per year if determined medically necessary 	<p>\$30 copay per office visit</p> <ul style="list-style-type: none"> • 30 visits only per year if determined medically necessary <p>No Deductible</p>	<p>\$30 copay per office visit</p> <ul style="list-style-type: none"> • 30 visits only per year if determined medically necessary <p>No Deductible</p>

Chiropractic - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Chiropractic (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Chiropractic treatment for chronic subluxation or rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/conditions</i> • <i>Rolfing</i> • <i>Massage therapy</i> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Alternative treatments	High Option	Standard Option	Wellness Option
<p>Acupuncture- 30 visits per year if determined medically necessary by a Doctor of Medicine or osteopathy for:</p> <ul style="list-style-type: none"> • Acupuncture treatment for other medical conditions will be covered only if the following conditions are met: <ul style="list-style-type: none"> - There is evidence-based medical literature that clearly supports the safety, efficacy and appropriateness of this treatment for the specific medical condition for which authorization is requested - Acupuncture must be part of a coordinated plan of care • Biofeedback is only covered for treatment of Raynaud’s disease or phenomenon and urinary or fecal incontinence 	<p>\$30 copay per office visit - Adult</p> <ul style="list-style-type: none"> • 30 visits adults only per year if determined medically necessary <p>\$20 copay per office visit - Children up to age 26</p> <ul style="list-style-type: none"> • 20 visits per year if determined medically necessary 	<p>\$30 copay per office visit</p> <p>No deductible</p>	<p>\$30 copay per office visit</p> <p>No deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option	Wellness Option
<p>Coverage is provided for:</p> <ul style="list-style-type: none"> • Tobacco Cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence • Diabetes self management • Childhood obesity screening programs and treatment interventions 	<p>No copay for educational classes and programs. Regular plan benefits apply to medical services.</p>	<p>No copay for educational classes and programs. Regular plan benefits apply to medical services.</p>	<p>\$0</p> <p>Not subject to deductible</p>

Educational classes and programs - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Educational classes and programs (cont.)	High Option	Standard Option	Wellness Option
	No copay for Tobacco Cessation drugs in conjunction with Tobacco Cessation Program. Quantity limits apply maximum of two 90-day treatment regiments.	No copay for tobacco cessation drugs in conjunction with Tobacco Cessation Program. Quantity limits apply maximum of two 90-day treatment regiments. No deductible	
Diabetic Education	\$40 copay per office visit \$20 copay per office visit for children up to age 26	\$40 copay per office visit No deductible	\$0 Not subject to deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hypnotherapy</i> • <i>Acupuncture is not covered under the Tobacco Cessation Counseling benefit. However, acupuncture for tobacco cessation is covered under the acupuncture benefit subject to the acupuncture copay and benefit limitation</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is: \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- If you are seen in a network facility and have services (anesthesiology, emergency departments physicians, radiologists, pathologists, etc.) rendered by an out-of-network provider, you will not be responsible for any costs outside of your in-network cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Please contact us if you receive any bills from out-of-network providers related to an in-network hospital visit.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay		
	High Option	Standard Option	Wellness Option
Surgical procedures			
A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	Outpatient - \$200 copay per visit, No deductible (included in hospital/facility outpatient copay) Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	Outpatient - 30% coinsurance/\$2,000 Max per surgery, Deductible applies Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible

Surgical procedures - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Surgical procedures (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over their normal weight according to current underwriting standards; eligible members must be age 18 or over. Note: Refer to our web site www.phs.org/fehb for more information regarding coverage and exclusion criteria. • Insertion of internal prosthetic devices. See 5 (a) - <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Outpatient - \$200 copay per visit, No deductible (included in hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per surgery, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; (see Foot care)</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay		
Reconstructive surgery	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonable be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <ul style="list-style-type: none"> • Gender Affirming Surgery <ul style="list-style-type: none"> - Transgender services with a diagnosis of gender dysphoria, please contact health plan for detailed information. Prior Authorization is required. - Male-to-Female(MtF) - Surgical procedures include, but are not limited to: penectomy, orchiectomy, vaginoplasty, vulvoplasty, labiaplasty, clitoroplasty. - Female-to-Male (FtM) - Surgical procedures include, but are not limited to: mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, metoidoplasty/phalloplasty (including penile prosthesis), urethroplasty, scotoplasty (including testicular prostheses). 	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per surgery, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

Reconstructive surgery - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Reconstructive surgery (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> <i>Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

High, Standard and Wellness Options

Benefit Description	You pay		
Oral and maxillofacial surgery	High Option	Standard Option	Wellness Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures; • TMJ benefit (Limited) - Please refer to Section 5(h) Dental Benefits. 	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per surgery, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>
<p><i>Not covered</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Organ/tissue transplants	High Option	Standard Option	Wellness Option
<p>These solid organ transplants are covered. Solid organ transplants are limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas <p>These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to <i>Other services</i> in Section 3 for prior authorization procedures.</p>	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>

Organ/tissue transplants - continued on next page
High, Standard and Wellness Options Section 5(b)

Benefit Description	You pay		
Organ/tissue transplants (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Autologous tandem transplants for <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paraxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia 	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>

Organ/tissue transplants - continued on next page
 High, Standard and Wellness Options Section 5(b)

Benefit Description	You pay		
Organ/tissue transplants (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing’s sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors <p>Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.</p> <p>Refer to <i>Other services</i> in Section 3 for prior authorization procedures:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi’s, PNH, Pure Red Cell Aplasia) - Myelodysplasia/myelodysplastic syndromes 	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>

Organ/tissue transplants - continued on next page
 High, Standard and Wellness Options Section 5(b)

Benefit Description	You pay		
Organ/tissue transplants (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma <p>These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient’s condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia 	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>

Benefit Description	You pay		
Organ/tissue transplants (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for <ul style="list-style-type: none"> - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyoarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) 	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>

High, Standard and Wellness Options

Benefit Description	You pay		
Organ/tissue transplants (cont.)	High Option	Standard Option	Wellness Option
<p><i>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.</i></p>	<p>Outpatient - \$200 copay per visit, No deductible (included in the hospital/facility outpatient copay)</p> <p>Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)</p>	<p>Outpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p> <p>Inpatient - 30% coinsurance/\$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance</p> <p>Subject to deductible</p>

Organ/tissue transplants - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Organ/tissue transplants (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except as shown above</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

High, Standard and Wellness Options

Benefit Description	You pay		
Anesthesia	High Option	Standard Option	Wellness Option
Professional services provided in - <ul style="list-style-type: none"> • Hospital (inpatient) 	Inpatient - \$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	30% coinsurance/ \$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
Professional services provided in - <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	\$25 copay per visit to primary care physician \$0 copay per visit to primary care physician for children up to age 26 \$40 copay per visit to specialist \$20 copay per office visit to specialist for children up to age 26 Outpatient - \$200 copay per visit, deductible does not apply (included in the hospital/facility outpatient copay)	\$30 copay per visit to primary care physician, No deductible \$40 copay per visit to specialist, No deductible Outpatient - 30% coinsurance/\$2,000 Max per surgery, Deductible applies	30% coinsurance Subject to deductible

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for the **High Option** plan.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment) for the **Standard Option** plan.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 per Self and Family enrollment) for the **Wellness Option** plan.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you are seen in a network facility and have services (anesthesiology, emergency departments physicians, radiologists, pathologists, etc.) rendered by an out-of-network provider, you will not be responsible for any costs outside of your in-network cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Please contact us if you receive any bills from out-of-network providers related to an in-network hospital visit.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

Benefit Description	You pay		
	High Option	Standard Option	Wellness Option
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced 	<p>\$100/day copay per admission up to 5 days</p>	<p>30% coinsurance/ \$2,000 Max per admission, Deductible applies</p>	<p>30% coinsurance Subject to deductible</p>

Inpatient hospital - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
	High Option	Standard Option	Wellness Option
Inpatient hospital (cont.) <ul style="list-style-type: none"> • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	\$100/day copay per admission up to 5 days	30% coinsurance/ \$2,000 Max per admission, Deductible applies	30% coinsurance Subject to deductible
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as phone, television, barber services, guest meals and beds • Private nursing care, except when medically necessary 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Intensive outpatient treatment is equal to 60 consecutive days and 60 consecutive equals one admission, confinement or episode of care. One copay will apply per 60 days or episode of care.</p> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$150 copay per visit	30% coinsurance/ \$2,000 Max per surgery Deductible applies	30% coinsurance Subject to deductible

Outpatient hospital or ambulatory surgical center - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Outpatient hospital or ambulatory surgical center (cont.)	High Option	Standard Option	Wellness Option
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	High Option	Standard Option	Wellness Option
<p>Skilled nursing facility (SNF): 60 days per member per Calendar year</p> <p>Note: We cover room and board and other necessary services that you require and a SNF provides. The Plan must preauthorize the services that your Plan physician recommends</p>	\$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	30% coinsurance Deductible applies	30% coinsurance Subject to deductible
<i>Not covered: Custodial care or domiciliary care</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Hospice care	High Option	Standard Option	Wellness Option
<p>The following services are covered for in-patient and in-home hospice benefits</p> <ul style="list-style-type: none"> • Inpatient hospice care • Physician visits by plan hospice physicians • Home health care by approved home health care personnel • Physical therapy • Medical supplies • Drugs and medication for the terminally ill patient • Respite care for a period not to exceed five continuous days for every 60 days of hospice care. Only two respite cares are available during a hospice benefit period <p>Notes: - Benefits are provided for in a Plan hospice or facility approved by the plan physician and preauthorized by the plan.</p> <p>The hospice benefit period must begin while you are covered with this benefit, and coverage through the plan must be continued throughout the benefit period in order for hospice benefits to continue.</p> <p>The hospice benefits period is defined as:</p> <p>Beginning on the date the plan physician certifies that you are terminally ill with a life expectancy of six months or less; and ending six months after it began, or upon death.</p>	\$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	30% coinsurance Deductible applies	30% coinsurance Subject to deductible

Hospice care - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Hospice care (cont.)	High Option	Standard Option	Wellness Option
If you require an extension of the hospice benefit period, the hospice must provide a new treatment plan and the plan physician must recertify your medical condition to us. No more than one additional hospice benefit period will be preauthorized by us.	\$100/day copay per admission up to 5 days (included in hospital/facility inpatient admission copay)	30% coinsurance Deductible applies	30% coinsurance Subject to deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Food, housing and delivered meals</i> • <i>Volunteer services</i> • <i>Comfort items</i> • <i>Homemaker and housekeeping services</i> • <i>Private duty nursing</i> • <i>Pastoral and spiritual counseling and</i> • <i>Bereavement counseling</i> 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option	Wellness Option
Local professional ambulance service when medically appropriate Ground Ambulance	\$50 copay per occurrence \$50 copay per occurrence	\$50 copay per occurrence \$50 copay per occurrence	30% coinsurance, Subject to deductible 30% coinsurance, Subject to deductible
Air ambulance	\$100 copay per occurrence	\$100 copay per occurrence	30% coinsurance, Subject to deductible

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- If you are seen in a network facility and have services (anesthesiology, emergency departments physicians, radiologists, pathologists, etc.) rendered by an out-of-network provider, you will not be responsible for any costs outside of your in-network cost-sharing (copays, coinsurance, deductibles, and non-covered services and supplies). Please contact us if you receive any bills from out-of-network providers related to an in-network hospital visit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

In determining whether you acted as a “reasonable layperson” we determine the following factors:

- Your belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- The time of day the care was provided

- The presenting symptoms
- Any circumstances that prevented you from using our established procedures for obtaining emergency care

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

No prior preauthorization is required for emergency care.

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

Emergencies within our service area

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

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

Emergencies outside our service area

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

Benefit Description	You pay		
Emergency within our service area	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office 	\$25 copay per visit to primary care physician \$0 copay per visit to primary care physician for children up to age 26 \$40 copay per visit to specialist \$20 copay per visit to specialist for children up to age 26	\$30 copay per visit to primary care physician \$40 copay per visit to specialist, No deductible \$200 copay per visit, No deductible	\$300 copay for the first 2 visits, No deductible Subsequent visits: 30% coinsurance, Subject to deductible
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$40 copay per visit	\$40 copay per visit No deductible	\$40 copay per visit No deductible
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors’ services 	\$150 copay per visit	\$200 copay per visit, No deductible If admitted to a hospital, then deductible and coinsurance will apply	\$300 per visit for the first 2 visits, No deductible applies 30% coinsurance, thereafter, Subject to deductible
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

High, Standard and Wellness Options

Benefit Description	You pay		
Emergency outside our service area	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$25 copay per visit to primary care physician \$0 copay per visit to primary care physician for children up to age 26 \$40 copay per visit to specialist \$20 copay per visit to specialist for children up to age 26	\$30 copay per visit to primary care physician \$40 copay per visit to specialist No deductible	30% coinsurance, Subject to deductible
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$40 copay per visit \$20 copay per visit for children up to age 26	\$40 copay per visit No deductible	\$40 copay per visit No deductible
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$150 copay per visit	\$200 copay per visit, No deductible If admitted to a hospital, then deductible and coinsurance will apply	\$300 per visit for the first 2 visits, No deductible applies 30% coinsurance, thereafter, Subject to deductible
<i>Not covered:</i> <ul style="list-style-type: none"> Elective care or non-emergency care Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area 	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option	Wellness Option
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	\$50 copay per occurrence	\$50 copay per occurrence	30% coinsurance, Subject to deductible
<ul style="list-style-type: none"> Ground ambulance 	\$50 copay per occurrence	\$50 copay per occurrence, No deductible	30% coinsurance, Subject to deductible
<ul style="list-style-type: none"> Air ambulance 	\$100 copay per occurrence	\$100 copay per occurrence, No deductible	30% coinsurance, Subject to deductible
Inter-Facility Transfer:	Nothing	Nothing	30% coinsurance, Subject to deductible
<ul style="list-style-type: none"> Ground Ambulance Air Ambulance 	\$100 copay per occurrence	No deductible \$100 copay per occurrence, No deductible	30% coinsurance, Subject to deductible

Ambulance - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Ambulance (cont.)	High Option	Standard Option	Wellness Option
<i>Not covered: Inter-Facility Transfer Services if not preauthorized</i>	<i>All charges</i>	<i>All charges</i>	<i>All charges</i>

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 per Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay		
Professional services	High Option	Standard Option	Wellness Option
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are not greater than for other illnesses or conditions.
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) 	\$25 copay per visit \$0 copay per office visit for children up to age 26	\$30 copay per visit No deductible	First 4 visits: \$20 copay, Not subject to deductible Subsequent visits 30% coinsurance, Subject to the deductible

Professional services - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Professional services (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy 	\$25 copay per visit \$0 copay per office visit for children up to age 26	\$30 copay per visit No deductible	First 4 visits: \$20 copay, Not subject to deductible Subsequent visits 30% coinsurance, Subject to the deductible
Applied Behavioral Analysis (ABA) Diagnosis and treatment for all children up to age 26	\$0 copay per visit	\$0 copay per visit No deductible	30% coinsurance Subject to deductible
Diagnostics	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility 	Nothing if received during the office visit or inpatient hospital admission; otherwise applicable physician visit copay	Nothing if received during the office visit or inpatient hospital admission; otherwise applicable physician visit copay No deductible	30% coinsurance Subject to deductible
Inpatient hospital or other covered facility	High Option	Standard Option	Wellness Option
Inpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services 	\$100/day copay per admission up to 5 days	30% coinsurance/ \$2,000 Max per admission, Deductible applies	30% coinsurance, Subject to deductible
Outpatient hospital or other covered facility	High Option	Standard Option	Wellness Option
Outpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment center, full-day hospitalization, or facility-based intensive outpatient treatment. <p>Intensive outpatient treatment is equal to 60 consecutive days and 60 consecutive equals one admission, confinement or episode of care. One copay will apply per 60 days or episode of care.</p>	\$150 copay per visit	30% coinsurance/ \$2,000 Max per event, Deductible applies	30% coinsurance Subject to deductible

Limitation	We may limit your benefits if you do not obtain a treatment plan.
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Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.**
- Federal law prevents the pharmacy from accepting unused medications.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is: \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 for Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medications.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, (except for out-of-area emergencies), or by mail. Mail order medications are available through OptumRx. You may contact OptumRx at 866-528-5829, TTY 711 or visit their website at www.optumrx.com/mycatarmartrx. Order forms are available from the Plans's Customer Service Center or on our website at www.phs.org/fehb (Click on Insurance Plans, Employer offered, Federal Employees, Mail Services).
- **What is a Formulary?** A drug formulary, or preferred drug list, is a continually updated list of medications and related products supported by current evidence-based medicine, judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and preservation of health. The primary purpose of the formulary is to encourage the use of safe, effective and most affordable medications. Presbyterian Health Plan administers a closed formulary, which means that non-formulary drugs are not routinely reimbursed by the plan. Medical exception policies provide access to non-formulary medication when Medical necessity is established. The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. For the most up-to-date formulary drug information visit

http://docs.phs.org/idc/groups/public/documents/communication/pel_00199170.pdf.

- **Why Use generic Drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your Plan less money than a name-brand drug. A generic equivalent will be dispensed if available. If you or your healthcare provider request a brand name drug in place of the generic, you pay the difference in price between the brand and generic, plus the applicable brand copay. If there is no generic available you will still have to pay the applicable brand copay.

- **Prescription medications prescribed by a Plan provider** and obtained at a network pharmacy will be dispensed for up to a 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. You have the option to purchase up to a 90-day supply of medications at a network Pharmacy. Under the 90-day at retail pharmacy benefit, Preferred and Non-preferred medications can be obtained from a network pharmacy. One retail copay will be assessed for each 30-day supply. You will be charged three of the applicable copays for a 90-day supply up to the manufacturer's usual maximum recommended dosing for the medication or the FDA maximum recommended dosage.
- **Medications purchased through the mail order** option will be for up to a 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage. Certain Specialty Pharmaceuticals must be obtained through the contracted Specialty Pharmacy network.
- **Specialty Pharmaceuticals** are not available through the mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill up to a 14-day supply to ensure patients can tolerate the new medication.

These are the dispensing limitations.

Prescription refill requests through a Plan pharmacy or the mail order option will be processed at or near the expected time at which the original supply of medication would be exhausted. Requests for early refills can be made to the Plan pharmacy, who can then request approval from the Plan. Vacation overrides require a Prior Authorization. Maximum of one 30-day supply override per medication per benefit/calendar year. Schedule II medications are limited to a maximum of 34-day dispensing. Replacement prescriptions resulting from loss, theft, or destruction are not a covered benefit.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications, should call our Customer Service Center at 505-923-5678 or 800-356-2219.

What if your drug Isn't on the Preferred Drug List (PDL)?

If your drug is not on the PDL, you may ask your provider to switch you to a covered drug or ask us to cover your drug through the Prior Authorization Process. To learn more about your plan's drug coverage or to initiate a Prior Authorization request, www.phs.org.

What is Prior Authorization?

Prior Authorization is a clinical evaluation process to determine if the requested Healthcare Service is Medically Necessary, a Covered Benefit, and if it is being delivered in the most appropriate healthcare setting. Our Medical Director or other clinical professional will review the requested Healthcare Service and, if it meets our requirements for Coverage and Medical Necessity, it is Authorized (approved) before those services are provided.

The Prior Authorization process and requirements are regularly reviewed and updated based on various factors including evidence-based practice guidelines, medical trends, Practitioner/Provider participation, state and federal regulations, and our policies and procedures.

Continuation of therapy using any drug is dependent upon its demonstrable efficacy.

Note that the prior use of free prescription medications (ie. Samples, free goods, etc) will not be considered in the evaluation of a members eligibility for medication coverage.”

Member Reimbursement

- If a medical Emergency occurs outside of our Service Area and you use an In-network Pharmacy, you will be responsible for payment of the appropriate Copay. We have a large, comprehensive pharmacy network; however, if you go to an Out-of-network Pharmacy, and they are unable to process the claim at point of service you can pay for the prescription and submit a Member Reimbursement Form. Reimbursement will be based on the negotiated rate between Presbyterian Health Plan and the dispensing pharmacy minus any copay or coinsurance that may apply. The form together with the itemized cash register receipt and the prescription drug detail (pharmacy pamphlet) must contain the following information:
- Patient's name
- Patient's Date of Birth
- Name of the drug

- Quantity dispensed
- NDC (National Drug Code)
- Fill Date
- Name of Prescriber
- Name and phone number of the dispensing pharmacy
- Reason for the purchase (nature of emergency)
- Proof of payment (copay of the check, credit card statement or a receipt showing that payment in full was received)
- Member Reimbursement forms are available by calling our Presbyterian Customer Service Center Monday through Friday from 7:00 a.m. to 6:00 p.m. at (505) 923-5678 or 1-800-356-2219. Hearing impaired users may call our TTY number at 711 or visit the Pharmacy page of our website at www.phs.org

High, Standard and Wellness Options

Benefit Description	You pay		
Tobacco cessation	High Option	Standard Option	Wellness Option
Tobacco and nicotine cessation medications that require a prescription by Federal Law. Quantity limits apply maximum of two 90-day regimens.	\$0 copay	\$0 copay	\$0 copay
Over the counter (OTC) Tobacco and Nicotine Cessation Products covered if prescribed by a plan doctor in conjunction with the Plan's Tobacco and Nicotine Cessation Program. Quantity limits apply maximum of two 90-day regimens.	\$0 copay	\$0 copay	\$0 copay
Covered medications and supplies	High Option	Standard Option	Wellness Option
<p>We cover the following medications and supplies on the Preferred drug list when prescribed by a Plan physician and obtained from a network pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i> • Insulin • Diabetic supplies limited to: <ul style="list-style-type: none"> - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Drugs to treat gender dysphoria (GNRH Analogs and Cross-Sex hormones) <ul style="list-style-type: none"> - Preferred formulary agents - Testosterone, Lupron, Lupron Depot - Prior Authorization is required 	<p>Retail</p> <p>Tier 0 - Maintenance Medication category to include medications and supplies used to treat diabetes, opioid overdose, and asthma.</p> <p>\$0 copay per 30 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage.</p> <p>Tier 1 - Preferred Generic Drugs</p> <p>\$10 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 2 - Preferred Brand Drugs</p> <p>\$75 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p>	<p>Retail</p> <p>Tier 0 - Maintenance Medication category to include medications and supplies used to treat diabetes, opioid overdose, and asthma.</p> <p>\$0 copay per 30 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage.</p> <p>Tier 1 - Preferred Generic Drugs</p> <p>\$10 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 2 - Preferred Brand Drugs</p> <p>\$50 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p>	<p>Retail</p> <p>Tier 0 - Maintenance Medication category to include medications and supplies used to treat diabetes, opioid overdose, and asthma.</p> <p>\$0 copay per 30 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage.</p> <p>Tier 1 - Preferred Generic Drugs</p> <p>\$10 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 2 - Preferred Brand Drugs</p> <p>\$50 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p>

Covered medications and supplies - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Covered medications and supplies (cont.)	High Option	Standard Option	Wellness Option
	<p>Tier 3 - Non-Preferred Drugs</p> <p>\$80 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 4 - Specialty Pharmaceuticals</p> <p>50% of plan allowance up to a maximum out-of-pocket of \$400 per prescription</p> <p>Mail order</p> <p>Tier 0 - Maintenance Medication (for certain chronic conditions). For more information, see Maintenance Medications note on page 71.</p> <p>2 copays per 90 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage.</p> <p>Tier 1 - Preferred Generic Drugs</p> <p>\$20 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 2 - Preferred Brand Drugs</p>	<p>Tier 3 - Non-Preferred Drugs</p> <p>\$80 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 4 - Specialty Pharmaceuticals</p> <p>50% of plan allowance up to a maximum out-of-pocket of \$400 per prescription</p> <p>Mail order</p> <p>Tier 0 - Maintenance Medication (for certain chronic conditions). For more information, see Maintenance Medications note on page 71.</p> <p>2 copays per 90 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage.</p> <p>Tier 1 - Preferred Generic Drugs</p> <p>\$20 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p><u>Tier 2 - Preferred Brand Drugs</u></p>	<p>Tier 3 - Non-Preferred Drugs</p> <p>\$80 copay per 30-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 4 - Specialty Pharmaceuticals</p> <p>50% of plan allowance up to a maximum out-of-pocket of \$400 per prescription</p> <p>Mail order</p> <p>Tier 0 - Maintenance Medication (for certain chronic conditions). For more information, see Maintenance Medications note on page 71.</p> <p>2 copays per 90 day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage.</p> <p>Tier 1 - Preferred Generic Drugs</p> <p>\$20 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 2 - Preferred Brand Drugs</p>

Covered medications and supplies - continued on next page

High, Standard and Wellness Options

Benefit Description	You pay		
Covered medications and supplies (cont.)	High Option	Standard Option	Wellness Option
	<p>\$100 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 3 - Non-Preferred Drugs</p> <p>\$150 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 4 - Specialty Pharmaceuticals</p> <p>Not available for Mail order</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>\$100 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 3 - Non-Preferred Drugs</p> <p>\$150 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 4 - Specialty Pharmaceuticals</p> <p>Not available for Mail order</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>	<p>\$100 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 3 - Non-Preferred Drugs</p> <p>\$150 copay per 90-day supply up to the maximum dosing recommended by the manufacturer or FDA maximum recommended dosage</p> <p>Tier 4 - Specialty Pharmaceuticals</p> <p>Not available for Mail order</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p>Note:</p> <p>Maintenance Medications are used for the management and prevention of complications from conditions such as high blood pressure, high cholesterol, diabetes, opioid overdose and asthma. For a full list of Maintenance Medications, please visit www.phs.org/fehb.</p> <p>Specialty Pharmaceuticals are self-administered, meaning they are administered by the patient, a family member or care-giver. Specialty Pharmaceuticals are often used to treat complex chronic, rare diseases and/or life threatening conditions. Most Specialty Pharmaceuticals require Prior Authorization and must be obtained through the specialty pharmacy network. Specialty Pharmaceuticals are often high cost, typically greater than \$600 for a 30-day supply.</p>			

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	High Option	Standard Option	Wellness Option
<p>Some specialty medications may qualify for third-party copay assistance is used, the Member shall not receive credit toward their maximum out-of-pocket or deductible for any copay or coinsurance amounts that are applied to a manufacturer coupon or rebate.</p> <p>Specialty Pharmaceuticals are not available through the mail order option and are limited to a 30-day supply. Certain Specialty Pharmaceuticals are limited to an initial fill, up to a 14-day supply to ensure patients can tolerate the new medication.</p> <p>The medications listed on the formulary are subject to change pursuant to the management activities of Presbyterian Health Plan. For a complete list of Specialty Pharmaceuticals and to determine which require Prior Authorization, please see the Presbyterian Pharmacy website at: www.phs.org/fehb (Prescription Drug Benefit).</p>			
<ul style="list-style-type: none"> • Contraceptive drugs and devices as listed in the ACA/HRSA site <p>Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.</p> <p>Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products and exceptions please see the Presbyterian Pharmacy website at www.phs.org/fehb.</p> <p>An emergency contraceptive is covered over-the-counter (OTC) at no cost if prescribed by a physician and purchased at a network pharmacy. Reimbursement for over-the-counter contraceptives can be submitted by downloading the Member Medical and Pharmacy Claim Form which can be found at www.phs.org/fehb</p>	\$0 copay	\$0 copay	\$0 copay

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> Oral fertility drugs 	50% of plan allowance	50% of plan allowance	50% of plan allowance
<ul style="list-style-type: none"> Special Medical Foods are covered when prescribed by a physician for treatment for Genetic Inborn Errors of Metabolism, when used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status, when you are under the physician’s ongoing care and when preauthorized by Us. 	30% of plan allowance	30% of plan allowance	30% of plan allowance
<p><i>Not covered</i></p> <ul style="list-style-type: none"> <i>Drugs and supplies for cosmetic purposes</i> <i>Drugs to enhance athletic performance</i> <i>Fertility drugs</i> <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> <i>Nonprescription medications unless specifically indicated elsewhere</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (see page 66)</i></p>			
Preventive medications	High Option	Standard Option	Wellness Option
<p>Preventive medications to promote better health as recommended by Affordable Care Act (ACA).</p> <p>The following drugs and supplements are covered without cost-share, even if over-the-counter are prescribed by a healthcare professional and filled at a network pharmacy.</p> <ul style="list-style-type: none"> Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age Folic acid supplements for women of childbearing age 400 & 800 mcg Liquid iron supplements for children age 0-1 year Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Anti-cholesterol agents "statins" Bowel preparations for members age 50 years or older. 	Nothing	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> Naloxone injectable with nasal atomizer. <p>Note: Preventive Medication with USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dosage Aspirin for certain patients. For current recommendation go to www.uspreventiveservicesasforce.org/BrowseRec/Index/browse-recommendations.</p> <p>Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.</p>	Nothing	Nothing	Nothing

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	High Option	Standard Option	Wellness Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-network pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements not listed as a covered benefit, even if a physician prescribes or administers them</i> • <i>Replacement prescriptions resulting from loss, theft, or destruction</i> • <i>Drugs from which there is a nonprescription equivalent available</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Nonprescription medications</i> • <i>Drugs for which prior approval has been denied or not obtained</i> • <i>Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products. Special Medical Foods are not covered for conditions that are not present at birth.</i> • <i>Bulk powders</i> • <i>Drugs that have not been approved by the FDA.</i> • <i>Injectable fertility drugs, including those provided in a physician's office.</i> • <i>Discount cards or Prescription Drug Savings cards to not apply to Deductible or Out-of-pocket maximums.</i> • <i>Herbal or alternative medicine and holistic supplements.</i> • <i>Vaccinations, drugs and immunizations for the primary intent of medical research or Non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance or functional capacity examinations related to employment.</i> • <i>Immunizations for the purpose of foreign travel, flight and or passports.</i> 	<p>All Charges</p>	<p>All Charges</p>	<p>All Charges</p>

Preventive medications - continued on next page

Benefit Description	You pay		
Preventive medications (cont.)	High Option	Standard Option	Wellness Option
<ul style="list-style-type: none"> • <i>Bioidentical hormone replacement therapy (BHRT), also known as bioidentical hormone therapy or natural hormone therapy including "all-natural" pills, creams, lotions and gels.</i> • <i>Prescription Drugs/Medications that are identified by Drug Efficacy Study Implementation (DESI) as Less than Effective LTE drugs are Not Covered.</i> • <i>Nutritional supplements as prescribed by the attending Practitioner/Provider or as sole source of nutrition are Not Covered.</i> • <i>Infant formula is Not Covered.</i> • <i>Drugs and supplied for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Nonprescription medications medicines</i> <p><i>Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefits. (See page 66).</i></p>	All Charges	All Charges	All Charges

Section 5(g). Dental Benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental and Vision Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible for the **High Option** plan.
- The calendar year deductible is: \$500 per person (\$1,000 per Self Plus One enrollment, or \$1,000 for Self and Family enrollment) for the **Standard Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is: \$2,000 per person (\$4,000 per Self Plus One enrollment, or \$4,000 for Self and Family enrollment) for the **Wellness Option** plan. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay		
	High Option	Standard Option	Wellness Option
Accidental injury benefit			
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$25 copay per visit to primary care physician \$40 copay per visit to specialist	\$30 copay per visit to primary care physician \$40 copay per visit to specialist	30% coinsurance Subject to deductible
Dental benefits (Limited) Limited dental services will be provided. Services include, but are not limited to, the following: <ul style="list-style-type: none"> • Oral surgery medically necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space. • Removal of infected teeth in preparation for certain surgeries or radiation therapy of the head and neck. 	\$25 copay per visit to primary care physician \$40 copay per visit to specialist	\$30 copay per visit to primary care physician \$40 copay per visit to specialist	30% coinsurance, Subject to deductible
Temporomandibular Joint Disorders (TMJ)			

Accidental injury benefit - continued on next page

High, Standard and Wellness Options

Benefit Description	You Pay		
Accidental injury benefit (cont.)	High Option	Standard Option	Wellness Option
<p>The treatment of Temporomandibular Joint disorders (TMJ) are subject to the same conditions and limitations as are applicable to treatment of any other joint in the body. Orthodontics are not covered unless the TMJ disorder is the result of an injury. (See also Oral and Maxillofacial surgery Section 5(a).</p>	<p>\$25 copay per visit to primary care physician</p> <p>\$40 copay per visit to specialist</p>	<p>\$30 copay per visit to primary care physician</p> <p>\$40 copay per visit to specialist</p>	<p>30% coinsurance, Subject to deductible</p>

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 505-923-5570 or toll-free at 866-221-9679. and talk with a registered nurse who will discuss treatment options and answer your health questions. For the hearing impaired, call our TTY line at 711 or 800-659-8331. The PresRN Line is confidential. You will be asked to provide some basic information to ensure that you are part of the Presbyterian Health Plan. There is no limit to the number of calls you can make.</p>
Services for deaf and hearing impaired	<p>Contact our Customer Service Center at 711 or toll-free at 800-659-8331.</p>
Pregnancies (Including High-Risk pregnancies)	<ul style="list-style-type: none"> • PRESious Beginnings is a statewide program that determines high-risk pregnancies and offers care management, literature and use of videos. Peri-Natal nurses are available for questions Monday through Friday 8:30 a.m. to 5:00 p.m. to assist with high-risk pregnancy questions. For additional information, call 505-724-6500 • Doula services are available for Members who deliver at Presbyterian Hospital. For more information, call 505-724-6500.
Presbyterian Healthcare Services	<p>Presbyterian Health Services offers several health improvement classes to Presbyterian Health Plan members and the general public. Fees vary according to status of participant. Visit our website at www.phs.org/fehb or call our Customer Service Center at 505-923-5678 or toll-free at 800-356-2219 or for the hearing impaired 505-923-5699 or toll-free 877-298-7407.</p>
Preventive Vision Exam and Discounts	<p>One preventive vision exam per year for adults and children and no charge on the High Option only. Discounts also available. Please visit Presbyterian Vision administered by Versant Health under the Davis Vision Network at www.davisvision.com for further information.</p>

Feature	Description
<p>Acupuncture, Chiropractic, Massage Therapy, Meals on Wheels, Fitness Center, Vision and Hearing Hardware discounts</p>	<p>Discounted services are available through Benefit Source and their contracted providers. Please refer to the Presbyterian Value Added flyer or visit www.benefitsource.org for further details.</p>
<p>Clinical Trials</p>	<p>Routine patient care costs that are incurred as a result of participation in a Cancer Clinical Trial in New Mexico are Covered.</p> <p>Routine patient care costs mean:</p> <ul style="list-style-type: none"> • Medical services or treatment that is a benefit under this health plan that would be Covered if the patient were receiving standard cancer treatment; or • A drug provided to a patient during a Cancer Clinical Trial if the drug has been approved by the Federal Food and Drug Administration, whether or not that organization has approved the drug for use in treating the patient’s particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug. <p>Routine patient care costs are Covered for Members in a Cancer Clinical Trial if:</p> <ul style="list-style-type: none"> • The Cancer Clinical Trial is undertaken for the purposes of the prevention of or the prevention of reoccurrence, early detection, or treatment of cancer for which no equally or more effective standard cancer treatment exists. • The Cancer Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent. • The Cancer Clinical Trial is being provided in New Mexico as part of a scientific study of a new therapy or intervention. • There is not a non-Investigational treatment equivalent to the Cancer Clinical Trial. • There is a reasonable expectation shown in clinical or pre-clinical data that the Cancer Clinical Trial will be at least as efficacious as any non-Investigational alternative. • There is a reasonable expectation based on clinical data that the medical treatment provided in the Cancer Clinical Trial will be at least as effective as any other medical treatment. • Pursuant to the patient informed consent, Presbyterian is not liable for damages associated with the treatment provided during any phase of a Cancer Clinical Trial. <p>The Clinical Trial Test must be conducted with the approval of a federal organization such as National Institutes of Health or the FDA.</p> <ul style="list-style-type: none"> • If services are not available from a Participating Provider/Practitioner, PHP will Cover services of a Non-Participating Provider/Practitioner only if the Provider/Practitioner agrees to accept PHP’s normal reimbursement for similar services, and services are provided in New Mexico. • Any care related to the Clinical Trial Test that is investigational requires Benefit Certification by PHP. Those medical services that are not investigational such as lab and X-ray services would require Preauthorization as identified in this Section 3. <p>Exclusions:</p> <ul style="list-style-type: none"> • Any Cancer Clinical Trials provided outside of New Mexico as well as, those that do not meet the requirements indicated above. • Costs of the Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.

	<ul style="list-style-type: none"> • Services from Non-Participating Providers/Practitioners, unless services from a Participating Provider/Practitioner are not available. Any Non-Participating services must be Preauthorized by PHP and provided for in New Mexico. The cost of a non-FDA-approved investigational drug, device or procedure. • The cost of a non-healthcare service that the patient is required to receive as a result of participation in the Cancer Clinical Trial. • Cost associated with managing the research that is associated with the Cancer Clinical Trial. • Costs that would not be Covered if non-investigational treatments were provided. • Cost of tests that are necessary for the research of the Clinical Trial. • Costs paid or not charged for by the Cancer Clinical Trial Providers.
<p>Video Visits</p>	<p>Video Visits is an alternative access point for members to receive care for non-urgent medical issues such as upper respiratory infections, flu, cold, cough, and allergies. For more information, please see page 26.</p>
<p>Pharmacy Cost Calculator</p>	<p>Members may utilize the Pharmacy Cost Calculator to look up prescriptions, determine coverage, copays, and locate participating pharmacies. This tool can be accessed at www.phs.org/fehb.</p>

Section 5(i). Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection (out-of-pocket maximums). These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 505-923-5678 or visit their website at www.phs.org/fehb.

BenefitSource, Inc. and Presbyterian Health Plan have teamed up to provide three dental plan options and three vision plan options for Federal employees and their dependents.

- **Option 1: Sandia Plan**

The Sandia Plan is the most economic dental plan option. Members obtain dental services from more than 1,000 participating dentists statewide. Members enjoy guaranteed low, pre-set fees on almost all types of dental work. Savings from 20%-60% are available for most basic and major dental services. Plan discounts are designed to encourage proper dental care by promoting early detection and regular dental health maintenance. Visit our website www.benefitsource.org for a complete schedule of dental benefits and the most current list of participating Sandia Plan dental providers.

- **Option 2: Elite Plan**

The Elite Plan is a comprehensive Indemnity/PPO dental plan. The Elite Plan provides you with the specific out-of-pocket costs when obtaining services from our participating PPO dental offices. No guess work. The in-network PPO benefit has no deductibles for Class I; preventive restorative silver endodontics, periodontics, oral surgery, crown & bridge services while offering members significant out-of-pocket copay savings on most dental procedures.

- **Option 3: Dental**

This plan is a comprehensive PPO dental Indemnity plan with the freedom of choice to see any licensed dentist. When using PPO Dental Plan providers, members have lower out-of-pocket costs and no balance billing for dental services. There is no deductible for Class I; preventive for Class II and Class III services. Payment is based upon maximum allowable charge of in-network providers. Visit our website www.benefitsource.org for a complete benefit schedule and the most current list of participating PPO dental providers.

- **Federal Employee Vision Benefits**

Your medical plan is providing a No Cost Eye Exam with Vision Service Plan (VSP). Please review your Presbyterian Federal Booklet for complete information.

For members who wish to enhance their vision coverage to include materials (eye glasses and contact lenses), BenefitSource will offer a separate Buy Up option. The Buy Up options lists a choice from a large network that includes private eye care providers and retail optical centers. Members will have an opportunity to purchase a material only Buy Up plan from BenefitSource directly. Visit our website, www.benefitsource.org for a complete list of vision benefits and participating vision offices.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan provider determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-Plan providers except for authorized services or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, diagnostic genetic testing, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services or supplies we are prohibited from covering under the Federal Law.
- Travel expenses, except for limited travel benefit for organ/tissue transplants cited in 5(b).

Section 7. Filing a Claim for Covered Services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior approval), including urgent care claims procedures). When you see Plan provider, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 505-923-5678 or toll-free at 800-356-2219 or for the hearing impaired at 505-923-5699 or toll-free at 877-298-7407, or at our Web site at www.phs.org/fehb.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name, date of birth, address, phone number and ID number;
- Name and address of the provider or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.
- For emergency or urgent care services outside the United States you are responsible for ensuring that claims are appropriately translated and that the monetary exchange, on the date of service, is clearly identified when submitting claims.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

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

Prescription drugs

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

Submit your claims to:

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

Deadline for filing your claim

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

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance) and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Center by writing to Presbyterian Health Plan, P.O. Box 27489, Albuquerque, NM 87125-7489 or calling 800-356-2219. For the hearing impaired, call our TTY line at 711 or toll-free at 800-659-8331. You may also contact us by fax at 505-923-8163 or visit our Web site at www.phs.org/fehb.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: P.O. Box 27489 Albuquerque, NM 87125-7489 ; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
 - e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you , free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you and our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

- 2** In the case of a post-service claim, we have 30 days from the date we receive your request to:
 - a) Pay the claim; or
 - b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

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If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physician's letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has the right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4

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

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (505) 923-5678 or toll-free at 800-356-2219 or for the hearing impaired at 505-923-5699 or toll-free at 877-298-7407. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.phs.org/fehb.

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

When we are the secondary payer, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. We follow the NAIC guidelines regarding Coordination of Benefits.

• TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

• Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or portal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCF=1500 to your provider, or sent it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

• Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB Plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB Plan so that your Plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.

- Extra care costs – cost related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not part of the patient’s routine care. (a) This plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information see page 93. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial.

Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

• **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-356-2219 or see our Website at www.phs.org/fehb.

We waive some costs if the Original Medicare Plan is your primary payor - We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other healthcare professionals.

We do not waive any costs if the Original Medicare Plan is your Primary Payor.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible

High Option You Pay **Without** Medicare: \$0

High Option You Pay **With** Medicare Part B: \$0

Standard Option You Pay **Without** Medicare: \$500 self only/\$1,000 family

Standard Option You Pay **With** Medicare Part B: \$500 self only/\$1,000 family

Wellness Option You Pay **Without** Medicare: \$2,000

Wellness Option You Pay **With** Medicare Part B: \$2,000

Benefit Description: Out-of-Pocket Maximum
High Option You Pay **Without** Medicare: \$6,350 self only/\$12,700 family
High Option You Pay **With** Medicare Part B: \$6,350 self only/\$12,700 family
Standard Option You Pay **Without** Medicare: \$6,350 self only/\$12,700 family
Standard Option You Pay **With** Medicare Part B: \$6,350 self only/\$12,700 family
Wellness Option You Pay **Without** Medicare: \$8,150 self only/ \$16,300 family
Wellness Option You Pay **With** Medicare Part B: \$8,150 self only/ \$16,300 family

Benefit Description: Part B Reimbursement Offered
High Option You Pay **Without** Medicare: N/A
High Option You Pay **With** Medicare Part B: N/A
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Part B: N/A
Wellness Option You Pay **Without** Medicare: N/A
Wellness Option You Pay **With** Medicare Part B: N/A

Benefit Description: Primary Care Physician
High Option You Pay **Without** Medicare: \$25
High Option You Pay **With** Medicare Part B: \$0
Standard Option You Pay **Without** Medicare: \$30 copay
Standard Option You Pay **With** Medicare Part B: \$0
Wellness Option You Pay **Without** Medicare: First 4 visits: \$20 copay, subsequent visits 30% coinsurance
Wellness Option You Pay **With** Medicare Part B: \$0

Benefit Description: Specialist
High Option You Pay **Without** Medicare: \$40
High Option You Pay **With** Medicare Part B: \$0
Standard Option You Pay **Without** Medicare: \$40 copay
Standard Option You Pay **With** Medicare Part B: \$0
Wellness Option You Pay **Without** Medicare: \$40 copay
Wellness Option You Pay **With** Medicare Part B: \$0

Benefit Description: Inpatient Hospital
High Option You Pay **Without** Medicare: \$100 copay/day, \$500 copay maximum
High Option You Pay **With** Medicare Part B: \$0
Standard Option You Pay **Without** Medicare: 30% Coinsurance, Subject to Deductible, \$2,000 max per admission
Standard Option You Pay **With** Medicare Part B: \$0
Wellness Option You Pay **Without** Medicare: 30% coinsurance
Wellness Option You Pay **With** Medicare Parts B: \$0

Benefit Description: Outpatient Hospital
High Option You Pay **Without** Medicare: \$200 copay
High Option You Pay **With** Medicare Part B: \$0
Standard Option You Pay **Without** Medicare: 30% Coinsurance, Subject to Deductible, \$2,000 max per admission
Standard Option You Pay **With** Medicare Part B: \$0
Wellness Option You Pay **Without** Medicare: 30% coinsurance
Wellness Option You Pay **With** Medicare Part B: \$0

Benefit Description: Incentives Offered
High Option You Pay **Without** Medicare: N/A
High Option You Pay **With** Medicare Part B: N/A
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Part B: N/A
Wellness Option You Pay **Without** Medicare: N/A
Wellness Option You Pay **With** Medicare Part B: N/A

You can find more information about how our plan coordinates benefits with Medicare in Presbyterian Health Plan at www.phs.org/fehb

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in the Presbyterian Senior Care Medicare Advantage Plan for FEHBP and also remain enrolled in the Presbyterian Health Plan's FEHBP Commercial Plan. The Presbyterian Senior Care Medicare Advantage Plan will be primary and the Presbyterian Health Plan's FEHBP Commercial plan will have coverage for prescription drugs. So, if you are enrolled in Medicare Part D, the Presbyterian Health Plan FEHBP Commercial plan will coordinate your prescription drug coverage with Medicare Part D. You must select a primary care provider from the Presbyterian Senior Care Plan, however, referrals are not required for network specialists, except for: Podiatry; Otolaryngology (Ear, Nose, and Throat); Occupational, Physical and Speech/Language Therapies. Presbyterian Senior Care and Presbyterian Health Plan's FEHBP Commercial plan will coordinate your medical benefits.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copays, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payor for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical Trials Cost Categories	<p>An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.</p> <ul style="list-style-type: none">• Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.• Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.• Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	See Section 4, page 21.
Copay	See Section 4, page 21.
Cost-sharing	See Section 4, page 21.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, accidental injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4, page 21.
Experimental or investigational service	The plan evaluates any new procedures, drug therapies, diagnostic genetic testing, treatments, devices, etc. to determine if they are Experimental/investigational in nature. This evaluation includes review of current literature published in peer review journals and appropriate information from governmental regulatory bodies, such as the FDA. We also utilize reliable evidence (consensus of opinion in the medical community) to determine if the procedure, drug therapies, treatments, devices, etc. is contraindicated for the particular indication which it has been prescribed. Please contact the plan for a more detailed explanation of this evaluation process.
Gender dysphoria	The formal diagnosis used by psychologists and physicians to describe people who experience significant dysphoria (discontent) with the sex and gender they were assigned at birth.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

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

Plan allowance Plan allowance means the maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the provider as it may be reduced by the co-insurance, deductible or amount beyond the annual maximum.

You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprise Act.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not the claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Center at 505-923-5678 or 800-356-2219 or TTY for the hearing impaired at 711 or toll-free at 800-659-8331 or by accessing our website at www.phs.org/fehb. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to Presbyterian Health Plan.

You

You refers to the enrollee and each covered family member.

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

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- Subrogation.....89-93, 95-97
- Substance Use Disorder...15-20, 64-65, 99, 101-104
- Surgery...5-6, 14-20, 25-59, 77-78, 82, 101-102
- Oral.....44-55, 77-78, 82
- Outpatient...15-20, 25-59, 61-65, 89-93, 99-104
- Reconstructive.....44-55
- Syringes.....69-76
- Temporary Continuation of Coverage (TCC)**.....2-3, 7-11
- Transplants.....25-55, 83
- Treatment therapies.....25-43
- Vision care**.....99-102
- Vision services.....21-22, 37-38, 90
- Wheelchairs**.....25-43
- Workers' Compensation.....86-97
- X-rays**.....25-59, 89-93, 95-97

Summary of Benefits for the High Option of the Presbyterian Health Plan - 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.phs.org/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: Primary Care Physician \$25 - \$0 copay per visit for children up to age 26 Specialist \$40 - \$20 copay per visit for children up to age 26 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	25
Services provided by a hospital: Inpatient	\$100/day up to 5 days	56-57
Services provided by a hospital: Outpatient	\$150	57-58
Emergency benefits: In-area	\$40 urgent care center; \$150 for ER visit	61
Emergency benefits: Out-of-area	\$40 urgent care center; \$150 for ER visit	62-63
Mental health and substance use disorder treatment:	Regular cost sharing \$25 copay per visit \$0 copay per office visit for children up to age 26	64-65
Prescription drugs (Retail and Mail Order)	Tier 0 - \$0 Maintenance Medication (for certain chronic conditions); Mail order \$0 Tier 1 - \$10 Generic (Preferred) drugs; Mail order \$20 Tier 2 - \$75 Brand (Preferred) drugs; Mail order \$100 Tier 3 - \$80 non-Brand (Non-preferred) drugs; Mail order \$150 <u>Tier 4 – Specialty Pharmaceuticals</u> 50% of the plan allowance up to a maximum out-of-pocket of \$400 per prescription; Not available mail order	69-76
Dental care	Limited benefit. Applicable physician visit copay	77-78

High Option Benefits	You pay	Page
Vision care	30% of the plan allowance Applicable physician visit copay (eye exam for children).	37-38
Special features:	Flexible benefits option; Services for deaf and hearing impaired, pregnancies, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, cancer clinical trials, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts.	79-81
Protection against catastrophic costs (your out-of-pocket maximum):	Nothing after \$6,350/Self Only or \$12,700/ Self Plus One and Self and Family enrollment per year Some costs do not count toward this protection	21-22

Summary of Benefits for the Standard Option of the Presbyterian Health Plan - 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.phs.org/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: Primary Care Physician \$30 Specialist \$40 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	25
Services provided by a hospital: Inpatient	30% coinsurance* /\$2,000 Max per admission Deductible applies	56-57
Services provided by a hospital: Outpatient	30% coinsurance* /\$2,000 Max per surgery Deductible applies	57-58
Emergency benefits: In-area	\$40 urgent care center; \$200 for ER visit	61
Emergency benefits: Out-of-area	\$40 urgent care center; \$200 for ER visit	62-63
Mental health and substance use disorder treatment:	Regular cost sharing \$30 copay per visit No deductible	64-65
Prescription drugs (Retail and Mail Order)	Tier 0 - \$0 Maintenance Medication (for certain chronic conditions); \$0 Mail order Tier 1 - \$10 Generic (Preferred) drugs; \$20 Mail order Tier 2 - \$50 Brand (Preferred) drugs; \$100 Mail order Tier 3 - \$80 non-Brand (Non-preferred) drugs; \$150 Mail order <u>Tier 4 - Specialty Pharmaceuticals</u> 50% of the plan allowance up to a maximum out-of-pocket of \$400 per prescription, not available mail order	69-76
Dental care	Limited benefit	77-78

	Applicable physician visit copay	
Vision care	50% of the plan allowance Applicable physician visit copay (eye exam for children).	37-38
Special features:	Flexible benefits option; Services for deaf and hearing impaired, pregnancies, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, cancer clinical trials, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts.	79-81
Protection against catastrophic costs (your out-of-pocket maximum):	Nothing after \$6,350/Self Only or \$12,700/Self Plus One enrollment or Self and Family enrollment per year. Some costs do not count toward this protection.	21-22

Summary of Benefits for the Wellness Option of the Presbyterian Health Plan - 2023

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.phs.org/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay Primary Care Physician First 4 visits: \$20 copay Subsequent visits: 30% coinsurance* Specialist \$40 copay	25
Services provided by a hospital: Inpatient	30% coinsurance*	56-57
Services provided by a hospital: Outpatient	30% coinsurance*	57-58
Emergency benefits: In-area	Urgent care \$40 per visit No deductible Emergency First 2 visits: \$300 copay No deductible Subsequent Visits: 30% coinsurance Subject to deductible	61
Emergency benefits: Out of the area	Urgent care \$40 copay Emergency First 2 visits \$300 copay Subsequent Visits: 30% coinsurance*	62-63
Mental Health and Substance use disorder treatment	Regular cost sharing First 4 visits \$20 copay Subsequent visits 30% coinsurance*	64-65
Prescription drugs (Retail and Mail Order)	Tier 0 - \$0 Maintenance Medication (for certain Chronic conditions): Mail order \$0 Tier 1 - \$10 Generic (Preferred) drugs; Mail order \$20 Tier 2 - \$50 Brand (Preferred) drugs; Mail order \$100 Tier 3 - \$80 non-Brand (Non-preferred) drugs; Mail order \$150 Tier 4 - Specialty Pharmaceuticals 50% of the plan allowance up to maximum of \$400 per prescription (Not subject to deductible)	69-76

	Not available mail order	
Dental Care	Limited benefit Applicable physician visit copayment	77-78
Vision	30% of the plan allowance Applicable physician visit copay (eye exam for children).	37-38
Special features:	Flexible benefits option: Services for deaf and hearing impaired, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, cancer clinical trials, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts.	79-81
Protection against catastrophic costs (your out-of-pocket maximum):	Nothing after \$8,150/Self Only or \$16,300/ Self Plus One and Self and Family enrollment per year Some costs do not count toward this protection	21-22

2023 Rate Information for Presbyterian Health Plan

2023 Rate Information for - Presbyterian Health Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

New Mexico

High Option Self Only	P21	\$259.72	\$210.22	\$562.73	\$455.47
High Option Self Plus One	P23	\$560.52	\$506.27	\$1,214.46	\$1,096.92
High Option Self and Family	P22	\$611.42	\$492.97	\$1,324.74	\$1,068.11

New Mexico

Standard Option Self Only	PS4	\$259.72	\$134.32	\$562.73	\$291.02
Standard Option Self Plus One	PS6	\$560.52	\$333.97	\$1,214.46	\$723.60
Standard Option Self and Family	PS5	\$611.42	\$314.60	\$1,324.74	\$681.64
Wellness Option Self Only	PS1	\$259.72	\$89.45	\$562.73	\$193.81
Wellness Option Self Plus One	PS3	\$560.52	\$232.10	\$1,214.46	\$502.88
Wellness Option Self and Family	PS2	\$611.42	\$209.14	\$1,324.74	\$453.14