# True Health New Mexico

**www.truehealthnewmexico.com**

**Customer Service: 1-844-508-4677**

truehealth™ new mexico

**2021**

## A Health Maintenance Organization (High Option)

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.

**IMPORTANT**
- Rates: Back Cover
- Changes for 2021: Page 14
- Summary of Benefits: Page 80

**Serving: New Mexico (all counties)**

**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:

**EL1 High Option - Self Only**
**EL3 High Option - Self Plus One**
**EL2 High Option - Self and Family**

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

**Important Notice from True Health New Mexico About**
**Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that True Health New Mexico's 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.

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**Please Be Advised**

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% 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% 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).

# Table of Contents

## Introduction

This brochure describes the benefits of True Health New Mexico under contract (CS 2959) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-844-508-4677 or through our website: www.truehealthnewmexico.com/federal-employees. The address for True Health New Mexico administrative offices is:

True Health New Mexico
P.O. Box 37200
Albuquerque, New Mexico 87176-9914

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, 2021, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2021, 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 True Health New Mexico.
- 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 Health Care Fraud!

Fraud increases the cost of health care 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 health care provider, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care 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) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that 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 for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-844-508-4677 and explain the situation.

**CALL THE HEALTH CARE FRAUD HOTLINE**

1-877-499-7295

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)
- Your child age 26 or over (unless he/she was 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 services or coverage for yourself or for someone else 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 may be responsible for all benefits paid during the period in which premiums were not paid. You may be billed directly 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

True Health New Mexico complies with all 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 health care 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, take notes, ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine 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, 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.

**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 health care 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 more information on patient safety, please visit:

- jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- 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 health care providers and improve the quality of care you receive.
- npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

**Preventable Healthcare Acquired Conditions ("Never Events")**

When you enter the hospital for treatment of one medical problem, you don't 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or 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 health care 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 to 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. Plan providers may not bill or collect payment from True Health New Mexico members for any costs associated with a Never Event. If you believe you are being incorrectly charged for costs related to a Never Event that occurred at a Plan provider, please contact us at 1-844-508-4677.

# 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)**

  Coverage under this plan qualifies as minimum essential coverage (MEC). Please visit the Internal 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/healthcare 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, and give you brochures for other plans 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
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is for you and one eligible family member. Self and Family coverage is for you, and one eligible family member, or 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.

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 or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.**

If you have a qualifying life event (QLE) - such as marriage, divorce, or the 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 a valid common law marriage) 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 in the chart below.

| Children | Coverage |
|---|---|
| Natural children, adopted children, and stepchildren | Natural, adopted children and stepchildren are covered until their 26th birthday. |
| Foster children | 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 | 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 | 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 | Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday. |

You can find additional information at www.opm.gov/healthcare-insurance. Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

- **Children's Equity Act**

OPM has implemented 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 for 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 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, as appropriate, 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 2021 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 2020 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 from 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, or 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 for 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 additional information about your coverage choices, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. 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). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

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

- **Converting to individual coverage**

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 1-844-508-4677 or visit our website at www.truehealthnewmexico.com/federal-employees.

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the ACA's Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides 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. True Health New Mexico holds the following accreditation: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit www.ncqa.org.

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care 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 copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

**General features of our High Option**

Our Plan includes no referrals, no out-of-pocket for preventive care, no copay for behavioral health office visits, no copay for drugs on the $0 Drug List, and no copay for routine pediatric vision exams. The Plan also provides out-of-network benefits for emergency services. A $250 deductible for Self Only applies to some services and a $500 deductible for Self Plus One and Self and Family applies to some services.

**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. We do not require a referral from your primary care physician in order to see a specialist. However, some specialists may request a referral from your primary care physician prior to scheduling a visit.

**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 (copayments, coinsurance, deductibles, and non-covered services and supplies).

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

## 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, and our providers. 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.

- True Health New Mexico is a for-profit, physician-led health plan committed to keeping New Mexicans healthy.
- We have been in existence since 2018.

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, True Health New Mexico at www.truehealthnewmexico.com/federal-employees. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 1-844-508-4677 or write to True Health New Mexico, P.O. Box 37200, Albuquerque, NM 87176-9914. You may also visit our website True Health New Mexico at www.truehealthnewmexico.com/about-us/.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website True Health New Mexico at www.truehealthnewmexico.com/federal-employees 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 is New Mexico and includes all counties in the state.

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

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

# Section 2. Changes for 2021

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.

Changes to this Plan

- Organ/Tissue Transplants - We now provide reimbursement for travel expenses related to an approved organ or tissue transplant received by a member at a center of excellence up to $10,000 per lifetime. Previously there was no reimbursement. (See page 45.)
- Specialty Drugs - We removed the deductible for Specialty drugs (Tier 4 and 5). (See page 56.)
- Injectables - To help you plan for prescription costs, injectables received via a retail, mail order, or specialty pharmacy are now a flat copay as follows: Generic (Tier 1) $5 copay, Preferred Brand (Tier 2) $30 copay, Non-preferred Brand (Tier 3) $70 copay, Preferred Specialty (Tier 4) $350 copay, and Non-preferred Specialty (Tier 5) $450 copay. (See page 56.)
- Insulin - You now pay a maximum of $25 copay for a 30 day supply of insulin purchased at a retail pharmacy or $50 copay for a 90 day supply purchased through mail order. (See page 56.)
- Premium - Your share of the non-Postal premium will increase for Self Only, Self Plus One, or Self and Family. (See page 80.)

## Section 3. How You Get Care

**Identification cards**

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 1-844-508-4677 or write to us at True Health New Mexico, P.O. Box 37200, Albuquerque, NM 87176-9914. You may also request replacement cards through our website: www.truehealthnewmexico.com/federal-employees.

**Where you get covered care**

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. You can receive covered services from a Plan provider without a required referral from your primary care physician or by another Plan provider in the network.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website: www.truehealthnewmexico.com/federal-employees. You can also call our Customer Service Department at 1-844-508-4677 and we can search the provider directory for you.

- **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.truehealthnewmexico.com/federal-employees. You can also call our Customer Service Department at 1-844-508-4677 and we can search the provider directory for you.

**What you must do to get covered care**

It depends on the type of care you need. We encourage you to choose a primary care provider when you enroll. This decision is important since your primary care provider can provide or arrange for most of your health care.

- **Primary care**

Your primary care provider can be a nurse practitioner, physician's assistant, or physician from the following specialties: family practice, general practice, internal medicine physician, pediatrics, or obstetrics/gynecology. Your primary care provider will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Specialty care is care you receive from providers other than a primary care provider.

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

- You may receive specialty care from plan providers without a referral.
- Although we do not require you to receive a referral to see a specialist, some specialists may request a referral from your primary care physician prior to scheduling a visit.

- Even though you may see a specialist without a referral, certain procedures and services may require prior authorization. Your Plan provider is responsible for obtaining prior authorization.
- 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 us to help you find 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 provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. Your plan provider is responsible for obtain prior authorization for inpatient admissions.

- **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 department immediately at 1-844-508-4677 (toll-free), (505) 633-8020 (in Albuquerque), or TTY 1-800-659-8331. If you are new to the FEHB Program, we will reimburse you 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;
- 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 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**

Your Plan provider must obtain prior approval from us for certain services. We will consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval process "prior authorization" or "preauthorization." If the request is approved, we will notify you and your Plan provider that we have authorized the request.

- **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 Plan provider must obtain prior authorization for:

  - Inpatient admissions to other healthcare facilities such as rehabilitation facilities, skilled nursing facilities, or residential treatment centers
  - Observation stays as an adjunct to surgical/radiology procedures or procedures performed in ambulatory surgical units
  - Advanced Imaging unless provided during emergency care or a covered inpatient admission
  - Non-emergent medical transportation including air medical transport
  - Partial hospitalization for mental health or substance use disorder treatment
  - Electroconvulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Physical, occupational, or speech therapy after the first ten (10) visits
  - Certain prescription drugs and supplies (drugs that require prior authorization are specified on the formulary by the initials PA)
  - Specialty medications
  - IV/Infusion therapy
  - Allergy serum and injections
  - Durable medical equipment
  - Orthotics and prosthetics
  - 3D imaging
  - Intima media thickness testing
  - Virtual colonoscopy/capsule endoscopy
  - Continuous EEG monitoring (elective admission)
  - Pneumograms/apnea monitors
  - Genetic testing
  - Specialty laboratory testing such as Oncotype
  - Dental services (accidental injury only)
  - Home health care
  - Dialysis
  - Hospice care
  - Care related to clinical trials
  - All outpatient or inpatient surgical procedures
  - Office-based surgical procedures
  - Reconstructive procedures
  - Orthognathic/oral/TMJ treatments
  - Weight loss/bariatric surgeries
  - Transplant services, solid organ, stem cell, bone marrow (including evaluation and travel expenses)
  - Spinal fusion and vertebroplasty
  - X-STOP® Spacer for spinal stenosis
  - Ventricular assist device (VAD)
  - Lung volume reduction
  - Transaortic or transapical valve insertion or replacement

- Pain management procedures, including but not limited to: symphathectomies, neurotomies, radiofrequency ablation, injection/infusions, blocks, pumps, implants, minimally invasive lumbar decompression, acupuncture
- Care received from a non-Plan provider unless in a medical emergency

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

First, your Plan provider or hospital must call us at 1-844-508-4677 before admission or services requiring prior authorization are rendered.

Next, your Plan provider will provide the following information:

- enrollee's name and Plan identification number
- 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 provider 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 at 1-844-508-4677. 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 at 1-844-508-4677. 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 for authorization of additional days. If you require additional non-routine care, preauthorization requirements listed under *You need prior Plan approval for certain services* apply. 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**

Except in a medical emergency you or your Plan provider must obtain preauthorization prior to you seeing a non-Plan provider. Your Plan provider must get our approval before sending you to receive services. If required medical services are not available from Plan providers, your Plan physician must request and obtain written authorization from us before you may receive services from a non-Plan provider. If you or your Plan provider do not obtain preauthorization from us for services or items from a non-Plan provider, we will not pay any amount for those services or items and you may be liable for the full price of those services or items. To verify if prior authorization has been approved, contact us **before** receiving services at 1-844-508-4677.

**Circumstances beyond your 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 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 health care 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.

1. 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 Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

**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.

**Copayment**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of $10 per office visit, and when you go in the hospital, you pay $500 per admission.

**Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is $250 per person under High Option. 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 $250 under High Option. 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 $500 under High Option.

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.

**Coinsurance**

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.

Example: In our Plan, you pay 10% of our allowance for durable medical equipment.

**Your catastrophic protection out-of-pocket maximum**

After your copayments, coinsurance, and deductible total $6,000 for Self Only or $6,000 per person for Self Plus One, or $12,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. **The maximum annual limitation on cost sharing listed under Self Only of $6,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.**

Example Scenario: Your plan has a $6,000 Self Only maximum out-of-pocket limit and a $12,000 Self Plus One or $12,000 Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $12,000, an aggregate of other eligible family members will continue to contribute toward the out-of-pocket maximum up to the individual maximum of $6,000 or when qualified medical expenses for the family reaches the $12,000 maximum for the calendar year.

However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Vision services from a non-VSP provider
- Non-covered charges

Be sure to keep accurate records of your copayments and 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. |
| **When Government facilities bill us** | Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek 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 to pay for certain services and charges. Contact the government facility directly for more information. |

# High Option Benefits

See page 14 for how our benefits changed this year. Page 79 is a benefits summary. Make sure that you review the benefits that are available under this plan.

# Section 5. High Option

This Plan is a High Option plan. The benefit package is described in Section 5. Make sure that you review the benefits that are available under the plan in which you are enrolled.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact us at 1-844-508-4677 or visit our website at www.truehealthnewmexico.com/federal-employees.

Highlights of this Plan include, but are not limited to:

- $0 copay for preventive care visits to a primary care provider (PCP).
- $0 copay for many generic drugs used to treat several common chronic conditions.
- $0 copay for outpatient behavioral health visits, including for substance use disorder treatment.
- Access to True Health Wellness programs.
- Access to the Care Connect Line, a 24/7 nurse advice line and Virtual Clinic.
- Case and disease management programs for members with chronic conditions and complex healthcare needs.
- A secure member portal and mobile app for quick access to your health plan details.

## Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care 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.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.
- 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 |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "after the deductible".** | |
| **Diagnostic and treatment services** | **High Option** |
| Professional services of physicians<br>• In physician's office<br>• Office medical consultations<br>• Second surgical opinion<br>• Advanced care planning<br>• At home | $10 copay per visit with a primary care physician<br>$30 copay per visit with a specialist |
| Professional services of physicians<br>• During a hospital stay<br>• In a skilled nursing facility | Nothing |
| **Telehealth Services** | **High Option** |
| Professional services of physicians and other health care professionals delivered through:<br>• Interactive video visits<br>• Telephone visits<br>Note: Visits may be limited by provider type and/or location. | $10 copay per visit with a primary care physician<br>$30 copay per visit with a specialist<br>Nothing for visits with a Plan mental health or substance use disorder treatment provider |
| **Lab, X-ray and other diagnostic tests** | **High Option** |
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine Pap tests<br>• Pathology<br>• X-rays<br>• Non-routine mammograms<br>• Ultrasound<br>• Electrocardiogram and EEG | Nothing |

*Lab, X-ray and other diagnostic tests - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Lab, X-ray and other diagnostic tests (cont.)** | **High Option** |
| • Genetic testing<br><br>Note: We only cover genetic testing when we preauthorize the service. The test must not be considered experimental, investigational, or unproven. The test must be performed by a Plan CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. Genetic testing must also meet at least one of the following: the patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes), conventional diagnostic procedures are inconclusive, the patient has risk factors or a particular family history that indicates a genetic cause, the patient meets defined criteria that place him or her at high genetic risk for the condition. | Nothing |
| Advanced imaging such as:<br>• Computed tomography (CT) scans<br>• Magnetic resonance imaging (MRI) scans<br>• Positron emission topography (PET) scans<br>• Cardiac nuclear studies<br><br>Note: We only cover advanced imaging when we preauthorize the service. | $100 copay per procedure per body part |
| Sleep studies | $30 copay per study at home<br><br>$250 copay per study with an overnight stay at a provider office or at an outpatient facility |
| **Preventive care, adult** | **High Option** |
| Routine physical every year<br><br>The following preventive services are covered at the time interval recommended at each of the links below.<br>• 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/<br>• Screenings such as cancer, osteoporosis, depression, diabetes (Glucose/hemoglobin A1C measurement), 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<br>• Individual counseling on prevention and reducing health risks<br>• Well woman care 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 Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ | Nothing |

*Preventive care, adult - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Preventive care, adult (cont.)** | **High Option** |
| Note: Services must be coded by your doctor as preventive to be covered in full. Screenings are covered annually unless specifically stated.<br><br>Note: We only cover low dose CT imaging for lung cancer screening when we preauthorize the service.<br><br>Note: We only cover BRCA genetic counseling/testing when we preauthorize the service. | Nothing |
| Routine mammogram – covered for women | Nothing |
| Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. | Nothing |
| 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 copayments, coinsurance, and deductible. | |
| *Not covered:*<br>• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*<br>• *Immunizations, boosters, and medications for travel or work-related exposure.* | *All charges* |
| **Preventive care, children** | **High Option** |
| • 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<br>• Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html<br>• 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 |
| 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 copayments, coinsurance, and deductible. | |
| Note: Should you receive services for an illness, injury or condition during a preventive care examination, you may be charged the cost-share for professional services in a physician's office. See Section 5(a), *Diagnostic and treatment services.* | |

| Benefit Description | You pay |
|---|---|
| **Maternity Care** | **High Option** |
| Routine maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Postnatal care<br><br>Note: See *Section 5(a), Preventive care adults* on page 27 for benefit coverage of preventive maternity care. | $30 copay per office visit up to a maximum of $300 per pregnancy |
| • Delivery | $500 copay per admission |
| Breastfeeding support, supplies and counseling for each birth<br><br>Note: See *Section 5(a), Durable Medical Equipment* on page 35 for benefit coverage of breastfeeding pumps. | Nothing |
| Note: Here are some things to keep in mind:<br>• You do not need to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby.<br>• 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.<br>• 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 if performed after the mother's confinement.<br>• We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.<br>• Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).<br><br>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. | |
| *Not covered:*<br>• *Home births* | *All charges* |
| **Family planning** | **High Option** |
| Contraceptive counseling on an annual basis | Nothing |
| A range of voluntary family planning services, limited to:<br>• Voluntary sterilization (See Surgical procedures Section 5 (b))<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs (such as Depo Provera)<br>• Intrauterine devices (IUDs)<br>• Diaphragms or cervical caps | Nothing |

*Family planning - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Family planning (cont.)** | **High Option** |
| • Genetic testing during pregnancy is covered when medically necessary for certain conditions such as for cystic fibrosis, certain autosomal recessive conditions, certain x-linked conditions, and certain chromosome abnormalities<br><br>Note: We cover oral contraceptives, diaphragms, and cervical caps under the prescription drug benefit.<br><br>Note: We only cover genetic testing during pregnancy when we preauthorize the service. The test must not be considered experimental, investigational, or unproven. The test must be performed by a Plan CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. Genetic testing must also meet at least one of the following: the patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes), conventional diagnostic procedures are inconclusive, the patient has risk factors or a particular family history that indicates a genetic cause, the patient meets defined criteria that place him or her at high genetic risk for the condition. | Nothing |
| *Not covered:*<br>• *Reversal of voluntary surgical sterilization*<br>• *Genetic testing unless specifically noted as covered.* | |
| **Infertility services** | **High Option** |
| Diagnosis of infertility and medically necessary treatment of a physical condition causing infertility | $10 copay per office visit with a primary care physician<br><br>$30 copay per office visit with a specialist |
| *Not covered:*<br><br>*Treatment of infertility, such as:*<br>• *Artificial insemination:*<br>- *Intravaginal Insemination (IVI)*<br>- *Intracervical Insemination (ICI)*<br>- *Intrauterine Insemination (IUI)*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>- *In vitro fertilization (IVF)*<br>- *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)*<br>• *Services, procedures, and supplies related to ART procedures*<br>• *Intracytoplasmic sperm injection (ICSI)*<br>• *Fertility drugs including drugs used in conjunction with ART and assisted insemination procedures*<br>• *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos , donor sperm and related costs, donor eggs and related costs*<br>• *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos* | *All charges* |

*Infertility services - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Infertility services (cont.)** | **High Option** |
| • *Services, supplies, or drugs provided to individuals not enrolled in this Plan*<br>• *Cost of donor sperm*<br>• *Cost of donor egg* | *All charges* |
| **Allergy care** | **High Option** |
| • Testing and treatment<br>• Allergy injections<br>• Allergy serum | 10% of our allowable after the deductible |
| *Not covered:*<br>• *Provocative food testing*<br>• *Sublingual allergy desensitization* | *All charges* |
| **Treatment therapies** | **High Option** |
| • Chemotherapy and radiation therapy<br><br>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 41.<br>• Dialysis – hemodialysis and peritoneal dialysis<br>• Intravenous (IV)/Infusion Therapy<br><br>Note: Growth hormone is covered under the prescription drug benefit.<br><br>Note: Drugs for IV/Infusion therapy obtained through a Plan retail, mail order, or specialty pharmacy are covered under the prescription drug benefit. See Section 5(f).<br><br>Note: Applied Behavior Analysis (ABA) therapy is described in Section 5(e). | 10% of our allowable after the deductible |
| • Cardiac rehabilitation<br>• Pulmonary rehabilitation | $10 copay per visit |
| • Respiratory and inhalation therapy | $30 copay per visit |
| **Physical and occupational therapies** | **High Option** |
| Outpatient habilitative and rehabilitative services provided by:<br>• Qualified physical therapists<br>• Occupational therapists<br><br>Note: After the first ten visits, we only cover physical therapy if we pre authorize the additional visits. We only cover therapy when a Plan provider:<br>• orders the care<br>• identifies the specific professional skills the patient requires and the medical necessity for skilled services;<br>• indicates the length of time the services are needed; and | $10 copay per visit<br><br>Nothing per visit during a covered inpatient admission |

*Physical and occupational therapies - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Physical and occupational therapies (cont.)** | **High Option** |
| • expects significant improvement of a member's physical condition within two (2) months of beginning rehabilitative therapy. | $10 copay per visit<br>Nothing per visit during a covered inpatient admission |
| *Not covered:*<br>• *Long-term rehabilitative therapy except for treatment of autism spectrum disorder*<br>• *Exercise programs*<br>• *Maintenance therapy*<br>• *Vocational rehabilitation programs*<br>• *Therapies done primarily for educational purposes*<br>• *Services provided by local, state and federal government agencies, including schools* | *All charges* |
| **Speech therapy** | **High Option** |
| • Speech therapy provided by a licensed or certified speech therapist<br>Note: We only cover speech therapy after the first ten visits if we preauthorize the additional visits. We only cover therapy when a Plan provider:<br>• orders the care<br>• identifies the specific professional skills the patient requires and the medical necessity for skilled services;<br>• indicates the length of time the services are needed; and<br>• expects significant improvement of a Member's physical condition within two (2) months of beginning rehabilitative therapy. | $10 copay per visit<br>Nothing per visit during covered inpatient admission. |
| *Not Covered:*<br>• *Therapies done primarily for educational purposes*<br>• *Therapy for tongue thrust in the absence of swallowing problems*<br>• *Voice therapy for occupation or performing arts*<br>• *Services provided by local, state, and federal government agencies, including schools* | *All charges* |
| **Hearing services (testing, treatment, and supplies)** | **High Option** |
| • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist<br>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* | $10 copay per visit with a primary care physician<br>$30 copay per visit with a specialist |
| • External hearing aids and the evaluation for the fitting of hearing aids for children up to age eighteen (18), or up to age twenty-one (21) if still attending high school<br>• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants | 10% of our allowable after the deductible |

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

| Benefit Description | You pay |
|---|---|
| **Hearing services (testing, treatment, and supplies) (cont.)** | **High Option** |
| Note: For benefits for the devices, see Section 5(a) *Orthotic and Prosthetic Devices*. | 10% of our allowable after the deductible |
| *Not covered:*<br>• *Deluxe or luxury equipment when standard equipment is available and adequate*<br>• *Hearing aid batteries*<br>• *Hearing aids that are investigational*<br>• *Over-counter hearing assistive devices and personal sound amplification products available without a prescription*<br>• *Hearing services that are not shown as covered* | *All charges* |
| **Vision services (testing, treatment, and supplies)** | **High Option** |
| Medically necessary services due to disease or injury to the eye | $10 copay per visit with a primary care physician<br>$30 copay per visit with a specialist |
| • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)<br>Note: We only cover eyeglasses or contact lenses when we preauthorize the service.<br>Note: See *Preventive care, children* for eye exams for children. | 10% of our allowable after the deductible |
| For children through age eighteen (18)<br>• One eye refraction exam per calendar year<br>• One pair of lenses and frames per calendar year<br>Note: Your plan includes pediatric vision services through Vision Service Plan (VSP). For more information on your VSP plan, please visit our website at www.truehealthnewmexico.com/federal-employees. | Nothing with a VSP provider<br>50% of charges with a non-VSP provider |
| *Not covered:*<br>• *Eye glasses or contact lenses, except as shown above*<br>• *Eye exercises and orthoptics*<br>• *Eye surgery solely for the purpose of correcting refractive defects of the eye*<br>• *Replacement of all items referenced in this section due to loss, neglect, theft, misuse, abuse or for convenience* | *All charges* |

| Benefit Description | You pay |
|---|---|
| **Foot care** | **High Option** |
| Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes<br><br>Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts. | $10 copay per visit with a primary care physician<br><br>$30 copay per visit with a specialist |
| *Not covered:*<br>• *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*<br>• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* | *All charges* |
| **Orthopedic and prosthetic devices** | **High Option** |
| External prosthetic and orthotic devices, such as<br>• Artificial limbs and eyes<br>• Prosthetic sleeve or sock<br>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy<br>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome<br>• External hearing aids for children through age eighteen (18) or under twenty-one (21) if still attending high school<br>• Up to three (3) molded foot orthotic inserts and one (1) pair of shoes per calendar year medically necessary due to nerve damage from diabetes or other significant peripheral neuropathies<br><br>Note: We will only cover prosthetic and orthotic devices when preauthorized. We will only cover prosthetic and orthotic devices that we determine are medically necessary.<br><br>Note: We cover one FDA approved hearing aid per hearing impaired ear every thirty-six (36) months for dependent children under eighteen (18) years old (or under twenty-one [21] years of age if still attending high school). Covered Services include fitting and dispensing fees, and ear molds, as necessary to maintain optimal fit of the hearing aids. Services must be dispensed by prescription and provided by a Plan audiologist, hearing aid dispenser, or physician. | 10% of our allowable after the deductible |
| Internal prosthetic devices, such as:<br>• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants<br>• Artificial joints<br>• Pacemakers<br>• Surgically implanted breast implant following mastectomy<br><br>Note: Internal prosthetic devices are covered under your hospital benefits. See Section 5(c) *Hospital benefits* for coverage of the inpatient or outpatient surgery to insert the device. | Nothing |

*Orthopedic and prosthetic devices - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Orthopedic and prosthetic devices (cont.)** | **High Option** |
| *Not covered:*<br>• *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups except as shown above*<br>• *Lumbosacral supports*<br>• *Corsets, trusses, elastic stockings, support hose, and other supportive devices*<br>• *Deluxe or luxury equipment when standard equipment is available and adequate*<br>• *Hearing aid batteries*<br>• *Hearing aids that are investigational*<br>• *Over-counter hearing assistive devices and personal sound amplification products available without a prescription*<br>• *Speech synthesis devices*<br>• *External penile devices*<br>• *Dental prostheses, devices, and appliances*<br>• *Spare or alternate use devices*<br>• *Repairs, adjustments, or replacements due to misuse or loss*<br>• *Prosthetic replacements provided less than 3 years after the last one we covered* | *All charges* |
| **Durable medical equipment (DME)** | **High Option** |
| We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. We cover items such as:<br>• Oxygen<br>• Dialysis equipment<br>• Hospital beds<br>• Wheelchairs<br>• Crutches<br>• Walkers<br>• Blood glucose monitors<br>• Insulin pumps<br>• Enteral nutrition products and supplies<br>• Special medical foods for inborn errors of metabolism<br><br>Note: Some blood glucose monitors may also be covered under the prescription drug benefit, see Section 5(f) *Prescription Drug Benefits.*<br><br>Note: We will only cover DME when preauthorized. We will only cover DME prescribed by your Plan provider and obtained through a Plan DME provider. | 10% of our allowable after the deductible |
| • Breastfeeding pumps, including any equipment that is required for pump functionality<br><br>Note: Limited to one pump per pregnancy obtained through a Plan DME provider. | Nothing |

*Durable medical equipment (DME) - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Durable medical equipment (DME) (cont.)** | **High Option** |
| *Not covered:*<br>• *Deluxe or luxury equipment when standard equipment is available and adequate*<br>• *Special features, upgrades, or equipment accessories unless Medically Necessary*<br>• *Audible prescription reading devices*<br>• *Repairs that exceed the purchase price*<br>• *Replacement or repair due to loss, theft, misuse, abuse, or destruction is not covered*<br>• *Replacement in cases where the patient improperly sells or gives away the equipment*<br>• *Replacement of DME solely for warranty expiration, or new and improved equipment becoming available*<br>• *Duplicate or extra DME for Member comfort, convenience, or travel*<br>• *DME obtained from the internet or from Out-of-Network Providers without preauthorization*<br>• *Paraffin baths, whirlpools, and cold therapy*<br>• *Physical fitness equipment*<br>• *Personal hygiene equipment*<br>• *Over-the-counter medical equipment and supplies*<br>• *Educational, vocational, or environmental equipment* | *All charges* |
| **Home health services** | **High Option** |
| Up to 100 visits per calendar year:<br>• 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.), home health aide, physical or occupational therapist, and speech and language pathologist.<br>• Services include oxygen therapy, intravenous therapy and medications.<br><br>Note: We only cover home healthcare services when preauthorized. | 10% of our allowable after the deductible |
| *Not covered:*<br>• *Nursing care requested by, or for the convenience of, the patient or the patient's family*<br>• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*<br>• *Private duty nursing* | *All charges* |

| Benefit Description | You pay |
|---|---|
| **Chiropractic** | **High Option** |
| Up to 25 visits per calendar year:<br>• Manipulation of the spine and extremities<br>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application | $30 copay per office visit |
| *Not covered:*<br>• *Services other than for musculoskeletal conditions*<br>• *Chiropractor services not shown above* | *All charges* |
| **Alternative treatments** | **High Option** |
| Up to 25 visits per calendar year:<br>• Acupuncture by a doctor of oriental medicine (D.O.M.) | $30 copay per office visit |
| Napropathy provided by a Doctor of Napropathy (D.N.) | $30 copay per office visit |
| *Not covered:*<br>• *Naturopathic services*<br>• *Hypnotherapy*<br>• *Biofeedback*<br>• *Massage therapy*<br>• *Rolfing*<br>• *Reiki*<br>• *Homeopathy* | *All charges* |
| **Educational classes and programs** | **High Option** |
| Coverage is provided for:<br>• Tobacco Cessation, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.<br>• Diabetes self-management<br>• Obesity education | Nothing for educational classes, programs, or counseling<br>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence |

## Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care 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.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.
- 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 health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **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 |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "after the deductible".** | |
| **Surgical procedures** | **High Option** |
| A comprehensive range of services, such as:<br>• Operative procedures<br>• Treatment of fractures, including casting<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedures<br>• Biopsy procedures<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies(see *Reconstructive surgery*)<br>• Surgical treatment of morbid obesity (bariatric surgery)<br><br>Note: We cover bariatric surgery only when preauthorized. We only cover bariatric surgery as a last resort, when the member's health is endangered and more conservative medical measures, including medications or diet and exercise programs, have not been successful. You must have had a complete nutritional, behavioral and medical evaluation and have a Body Mass Index (BMI) of forty (40)kg/m2 or at least thirty-five (35)kg/m2 if you have other serious illnesses such as diabetes, high blood pressure, or obstructive sleep apnea.<br>• Gender affirmation surgeries such as:<br>- Penectomy<br>- Orchiectomy | $250 copay per visit at an office<br><br>Nothing at an outpatient or inpatient hospital |

*Surgical procedures - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Surgical procedures (cont.)** | **High Option** |
| - Vaginoplasty<br>- Vulvoplasty<br>- Labiaplasty<br>- Clitoroplasty<br>- Mastectomy<br>- Hysterectomy<br>- Salpingo-oophorectomy<br>- Vaginectomy<br>- Metoidoplasty/phalloplasty<br>- Urethroplasty<br>- Scrotoplasty<br><br>Note: We cover gender affirmation surgeries only when preauthorized. For more information on preauthorization requirements, please contact us at 1-844-508-4677.<br>• Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information<br>• Voluntary sterilization such as:<br>- Vasectomy<br>- Tubal ligation<br>• Treatment of burns | $250 copay per visit at an office<br><br>Nothing at an outpatient or inpatient hospital |
| • Normal pre- and post-operative care by the surgeon | $30 copay per office visit |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Implants or devices related to the treatment of sexual dysfunction*<br>• *Services for the promotion, prevention, or other treatment of hair loss or hair growth*<br>• *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form*<br>• *Surgeries related to gender affirmation not shown above*<br>• *Routine treatment of conditions of the foot (see Foot care)* | *All charges* |
| **Reconstructive surgery** | **High Option** |
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>- the condition produced a major effect on the member's appearance and<br>- the condition can reasonably be expected to be corrected by such surgery | $250 copay per visit at an office<br><br>Nothing at an outpatient or inpatient hospital |

*Reconstructive surgery - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Reconstructive surgery (cont.)** | **High Option** |
| • 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; birthmarks; and webbed fingers and toes.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>- Surgery to produce a symmetrical appearance of breasts;<br>- Treatment of any physical complications, such as lymphedemas;<br>- Breast prostheses and surgical bras and replacements (see *Prosthetic devices*)<br><br>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.<br><br>Note: We only cover surgical services when we preauthorize the treatment. | $250 copay per visit at an office<br><br>Nothing at an outpatient or inpatient hospital |
| *Not covered:*<br>• 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 | *All charges* |
| **Oral and maxillofacial surgery** | **High Option** |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones;<br>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Excision of cysts and incision of abscesses when done as independent procedures;<br>• Oral surgery medically necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space; and<br>• Other surgical procedures that do not involve the teeth or their supporting structures. | $250 copay per visit at an office<br><br>Nothing at an outpatient or inpatient hospital |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* | *All charges* |

| Benefit Description | You pay |
|---|---|
| **Organ/tissue transplants** | **High Option** |
| These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for on page 17:<br>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis]<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Intestinal transplants<br>• Isolated small intestine<br>- Small intestine with the liver<br>- Small intestine with multiple organs, such as the liver, stomach, and pancreas<br>- Kidney<br>• Kidney-pancreas<br>• Liver<br>• Lung: single/bilateral/lobar<br>• Pancreas | Nothing |
| These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures.<br>• Autologous tandem transplants for<br>- AL Amyloidosis<br>- Multiple myeloma (de novo and treated)<br>- Recurrent germ cell tumors (including testicular cancer) | |
| **These blood or marrow stem cell transplants are subject to review of indicators for transplant such as refractory or relapsed disease, cytogenetics, subtype, or the diagnosis.**<br>The Plan extends coverage for the diagnoses as indicated below.<br>• Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Acute myeloid leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Advanced neuroblastoma<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) | |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** |
| - Hemoglobinopathy<br>- Infantile malignant osteopetrosis<br>- Kostmann's syndrome<br>- Leukocyte adhesion deficiencies<br>- Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia)<br>- Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)<br>- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia<br>- Sickle cell anemia<br>- X-linked lymphoproliferative syndrome<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Breast cancer<br>- Ependymoblastoma<br>- Epithelial ovarian cancer<br>- Ewing's sarcoma<br>- Multiple myeloma<br>- Medulloblastoma<br>- Multiple myeloma<br>- [Pineoblastoma]<br>- Neuroblastoma<br>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors | |
| **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.<br><br>Refer to *Other services* in Section 3 for prior authorization procedures: | |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** |
| • Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Acute myeloid leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy<br>- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Neuroblastoma | |
| **These blood or marrow stem cell transplants** are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.<br><br>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.<br>• Allogeneic transplants for<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Beta Thalassemia Major<br>- Chronic inflammatory demyelination polyneuropathy (CIDP)<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma | |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** |
| - Multiple myeloma<br>- Multiple sclerosis<br>- Sickle cell anemia<br>• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Breast cancer<br>- Chronic lymphocytic leukemia<br>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)<br>- Chronic myelogenous leukemia<br>- Colon cancer<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>- Multiple myeloma<br>• Multiple sclerosis<br>- Myelodysplasia/Myelodysplastic Syndromes<br>- Myeloproliferative disorders (MDDs)<br>- Non-small cell lung cancer<br>- Ovarian cancer<br>- Prostate cancer<br>- Renal cell carcinoma<br>- Sarcomas<br>- Sickle cell anemia<br>• Autologous Transplants for<br>- Advanced childhood kidney cancers<br>- Advanced Ewing sarcoma<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Aggressive non-Hodgkin's lymphoma<br>- Breast cancer<br>- Childhood rhabdomyosarcoma<br>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)<br>- Chronic myelogenous leukemia<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma | |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** |
| - Epithelial ovarian cancer<br>- Mantle cell (non-Hodgkin's lymphoma)<br>- Multiple sclerosis<br>- Small cell lung cancer<br>- Systemic lupus erythematosus<br>- Systemic sclerosis | |
| National Transplant Program (NTP) - All organ transplants must be medically necessary. Transplants will be performed at a site approved by us. | |
| 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. | |
| Note: We cover travel expenses including transportation, lodging, and food for member receiving an organ/tissue transplant up to $10,000 per lifetime. We will also cover travel expenses for one companion to accompany the member receiving the transplant. Members that are minors and receiving a transplant are allowed travel benefits for themselves, one or both parents, or a parent and a designated companion. A companion may be a spouse, domestic partner, family member, legal guardian, or any person not related to the Member but actively involved in the member's care. Coverage is limited to:<br>• Transportation to and from the transplant site, including charges for a rental car used during a period of care at the transplant facility<br>• Lodging while at, or traveling to and from, the transplant site<br>• Food while at, or traveling to and from, the transplant site | |
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except as shown above*<br>• *Implants of artificial organs*<br>• *Transplants not listed as covered* | *All charges* |
| **Anesthesia** | **High Option** |
| Professional services provided in –<br>• Hospital (inpatient)<br>• Hospital (outpatient)<br>• Skilled nursing facility<br>• Ambulatory surgical center | Nothing |
| Professional services provided in –<br>• Office | $10 copay per visit with a primary care physician<br>$30 copay per visit with a specialist |

## 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.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

| Benefit Description | You pay |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "after the deductible".** | |
| **Inpatient hospital** | **High Option** |
| Room and board, such as<br>• Ward, semiprivate, or intensive care accommodations<br>• General nursing care<br>• Meals and special diets<br><br>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.<br><br>Note: We cover observation stays greater than 24 hours as inpatient hospital.<br><br>Note: We only cover inpatient admissions when preauthorized. | $500 copay per admission |
| Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medications<br>• Diagnostic laboratory tests and X-rays<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) | Nothing |
| Not covered:<br>• Custodial care | *All charges* |

*Inpatient hospital - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Inpatient hospital (cont.)** | **High Option** |
| • Non-covered facilities, such as nursing homes, schools<br>• Personal comfort items, such as telephone, television, barber services, guest meals and beds<br>• Private nursing care | *All charges* |
| **Outpatient hospital or ambulatory surgical center** | **High Option** |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medications<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br>• Observation stays less than 24 hours<br><br>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. | $250 copay per visit at an outpatient hospital or other facility |
| **Extended care benefits/Skilled nursing care facility benefits** | **High Option** |
| Up to sixty (60) days per calendar year at a licensed Plan skilled nursing facility (SNF).<br><br>All necessary services are covered, including:<br>• Bed, board and general nursing care<br>• Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician<br>• Physician visits<br>• Physical, occupational, or speech therapy<br><br>Note: We only cover skilled nursing facility services when we preauthorize the service. | 10% of our allowable after the deductible |
| *Not covered:*<br>• *Custodial or domiciliary care*<br>• *Respite care*<br>• *Personal comfort items, such as telephone, television, barber services, and guest meals and beds* | *All charges* |

| Benefit Description | You pay |
|---|---|
| **Hospice care** | **High Option** |
| Hospice services provided by a licensed Plan hospice program including:<br>• Inpatient hospice care<br>• Provider visits by certified hospice providers<br>• Home health care services<br>• Physical therapy<br>• Medical supplies<br>• Prescription drugs and medication for the pain and discomfort specifically related to the terminal illness<br><br>Note: We only cover hospice services when we preauthorize the service. we cover services during a hospice benefit period beginning on the date your provider certifies that you are terminally ill with a life expectancy of six (6) months or less and ending six months after it began, or upon your death. If you require an extension of the hospice benefit period, your provider must re-authorize the service. We will not Authorize more than one additional Hospice benefit period. You must have coverage with our Plan throughout your hospice benefit period. | 10% of our allowable after deductible |
| *Not covered:*<br>• *Independent nursing*<br>• *Homemaker services*<br>• *Food, housing, or delivered meals*<br>• *Comfort items*<br>• *Private-duty nursing*<br>• *Supportive services provided to the family of a Terminally Ill Patient when the Member's benefit has ended*<br>• *Respite care* | *All charges* |
| **Ambulance** | **High Option** |
| Local professional ambulance service when medically appropriate<br><br>Note: We only cover non-emergency ambulance services when preauthorized. Cost sharing is waived for inter facility transfers due to level of care required. | 10% of our allowable after the deductible |
| *Not covered:*<br>• *Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan provider* | *All charges* |

# 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.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.
- 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 have an emergency, go to the nearest emergency room. Emergency rooms are open twenty-four (24) hours a day, seven (7) days a week. If necessary, dial 911 for help. If you are able, tell the emergency room staff that you are a Plan member and show them your ID card. They can then contact us for you. In situations where you cannot notify us immediately, contact us as soon as you can. We will provide direction and prior authorization as needed.

**Emergencies within and outside our service area**

You are covered for medical emergencies anywhere in the world. However:

- You should seek emergency medical treatment from **Plan providers** whenever possible.
- You should seek emergency care from the **nearest available** provider or facility, even if that it is a non-Plan provider. If you obtain emergency services from a non-Plan provider, your care will be covered as if you had visited a Plan provider.
- Non-emergency services from a non-Plan provider, such as follow-up care from a prior emergency room visit, require prior authorization.
- If you are admitted to a non-Plan facility, call us at 1-844-508-4677 to get prior authorization. If you are not able to contact us, a family member or caregiver should.
- If you are receiving emergency care from a non-Plan provider or facility, you can transfer to a Plan facility or provider to continue your care if it is safe for you to do so. Contact us or your in-network provider to help arrange a transfer.

| Benefit Description | You pay |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "after the deductible".** | |
| **Emergency within our service area** | **High Option** |
| • Emergency care at a doctor's office | $10 copay per visit with a primary care physician<br>$30 copay per visit with a specialist |
| • Urgent care at an urgent care center<br>• Emergency care at an urgent care center | $30 copay per visit |
| • Emergency care as an outpatient at a hospital, including physicians' services<br>Note: We waive the ER copay if you are admitted to the hospital. | $150 copay per visit |
| *Not covered: Elective care or non-emergency care* | *All charges* |
| **Emergency outside our service area** | **High Option** |
| • Urgent care at an urgent care center<br>• Emergency care at an urgent care center | $30 copay per visit |
| • Emergency care as an outpatient at a hospital, including doctors' services<br>Note: We waive the ER copay if you are admitted to the hospital. | $150 copay per visit |
| *Not covered:*<br>• *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers*<br>• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* | *All charges* |
| **Ambulance** | **High Option** |
| Professional ambulance service via air, ground, or sea when medically appropriate.<br>Note: The coinsurance is waived for inter-facility transfer due to level of care required.<br>Note: See 5(c) for non-emergency service. | 10% of our allowable after deductible |
| *Not covered: Air ambulance, unless medically necessary and no other transport is reasonably available.* | *All charges* |

## 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 is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.
- 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 |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "after the deductible".** | |
| **Professional services** | **High Option** |
| 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. |
| Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:<br>• Diagnostic evaluation<br>• Crisis intervention and stabilization for acute episodes<br>• Medication evaluation and management (pharmacotherapy)<br>• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment<br>• Treatment and counseling (including individual or group therapy visits)<br>• Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling<br>• Professional charges for intensive outpatient treatment in a provider's office or other professional setting<br>• Electroconvulsive therapy (ECT)<br>• Applied Behavior Analysis (ABA) therapy<br>• Transcranial magnetic stimulation (TMS)<br><br>Note: We only cover ECT and TMS services when we preauthorize the treatment. We will ask your provider to submit a information that establishes that ECT or TMS is medically necessary along with a treatment plan. We will only cover ECT and TMS services and related services and supplies that we determine are medically necessary. | Nothing |

| Benefit Description | You pay |
|---|---|
| **Diagnostics** | **High Option** |
| • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner<br>• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility<br>• Inpatient diagnostic tests provided and billed by a hospital or other covered facility<br><br>Note: We cover MRI/CT/PET tests under your medical benefit. See Section 5(a).<br><br>Note: For information on your hospital benefits, see Section 5(c). | Nothing |
| **Inpatient hospital or other covered facility** | **High Option** |
| Inpatient services provided and billed by a hospital, residential treatment center, or other covered facility<br>• Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services<br><br>Note: We only cover inpatient services when we preauthorize. | $500 copay per admission |
| **Outpatient hospital or other covered facility** | **High Option** |
| Outpatient services provided and billed by a hospital or other covered facility<br>• Services in approved treatment programs, such as partial hospitalization or facility-based intensive outpatient treatment<br><br>Note: We only cover partial hospitalization and full-day hospitalization services when preauthorized. | $250 copay per visit |
| **Not Covered** | **High Option** |
| *Not Covered:*<br>• *Care that is not clinically appropriate for the treatment of your condition*<br>• *Intelligence, IQ, aptitude ability, learning disorders, or interest testing not necessary to determine the appropriate treatment of a psychiatric condition*<br>• *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate*<br>• *Services that are custodial in nature*<br>• *Services rendered or billed by a school or a member of its staff*<br>• *Services provided under a federal, state, or local government programs*<br>• *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms*<br>• *Treatment foster care* | *All charges* |

*Not Covered - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Not Covered (cont.)** | **High Option** |
| • *Halfway houses or sober living facilities* | *All charges* |

## 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.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically. For Rx preauthorization requirements, see *Other Services* under *You need prior Plan approval for certain services* on page 17.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.

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 medication.
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy or by mail.
  - True Health New Mexico, through our relationship with CVS Caremark, is contracted with thousands of pharmacies across the country. To locate a participating pharmacy, please call CVS Caremark Customer Service at: 1-866-341-8561 OR visit our website at www.truehealthnewmexico.com/federal-employees.
  - Mail order medications are available through CVS Caremark Mail Service, which can be reached at 1-866-341-8561 OR through their website at www.caremark.com/wps/portal. Some medications may not be available through the CVS Caremark Mail Service.
  - Specialty medications that require special storage/administration/monitoring will typically be supplied through CVS Specialty Pharmacy. CVS Specialty Pharmacy can be reached at 1-800-237-2767. Specialty medications require a prior authorization for use. Although CVS Specialty Pharmacy is able to provide most specialty medications, some specialty medications are only available through a limited distribution process that uses pharmacies other than CVS Specialty. In those cases, an approval for the specialty medication will also allow for service at a Specialty Pharmacy other than CVS Specialty.
- **We use a formulary.** A drug formulary (also known as a preferred drug list) is a regularly updated list of medications and products. Coverage of medications on the formulary is determined by a group of healthcare professionals, including physicians and pharmacists. Formularies promote the use of safe, effective, and affordable medications.
  - True Health New Mexico uses a **closed formulary**, which means that drugs not listed on the preferred drug list are not usually reimbursed by the plan. Prescribers may request an exception for nonformulary medications through the prior authorization process. Medications listed on the formulary are subject to change, but members will be notified in advance of formulary changes, whenever possible. To view the most current formulary, please visit: www.truehealthnewmexico.com/federal-employees.
  - When you need a prescription medication, you and your doctor can choose from five different levels of the formulary. These are: Generics – Tier 1, Preferred Brands – Tier 2, Non-Preferred Brands – Tier 3, Preferred Specialty – Tier 4, and Non-Preferred Specialty – Tier 5. Each level has a different copayment. This gives you and your doctor the freedom to choose the medication that is right for you. At the same time, this will help you to better budget your health care dollars.

- Tier 1 Generic Medications: the lowest copayment level. Generic drugs offer the same level of safety and quality as their brand-name equivalents. They have the same amount of active ingredients as brand-name medications. You are required to use a generic version of the drug if one is available.
- Tier 2 Preferred-Brand Medications: the middle copayment level. These drugs are primarily brand medications and "preferred" because of their value and effectiveness. This tier may also include some generic medications.
- Tier 3 Non-Preferred Brand Medications: the higher copayment level. These medications are primarily brand drugs that are more expensive and have similar effectiveness as Tier 3 medications. This tier may also include higher cost generic medications.
- Tier 4 Preferred Specialty Medications: the higher copayment level. These include specialty medications, which usually treat complex and rare conditions. These drugs can be high-cost medications and biologicals regardless of how they are administered (injectable, oral, transdermal, or inhalant).
- Tier 5 Non-Preferred Specialty Medications: the highest copayment level. These also include specialty medications, which usually treat complex and rare conditions. These drugs can be high-cost medications and biologicals regardless of how they are administered (injectable, oral, transdermal, or inhalant) and have similar effectiveness as Tier 4.

- **These are the dispensing limitations.**
  - Retail: Up to a 90-day supply of medication can be filled at Plan retail pharmacies and one retail copayment will be applied for each 30-day supply (3 copayments for 90-day supplies).
  - Mail order: Up to a 90-day supply of medications may be dispensed at a mail order pharmacy and two copayments will be applied for each 90-day supply.
  - Specialty: Up to a 30-day supply of medications may be dispensed.
  - In general, medications cannot be refilled until at least 75% of the previous fill has been used. If an early refill is needed, you should work with your pharmacist and/or doctor to document the need. If an early refill is needed for travel/vacation, please contact True Health New Mexico Customer Service at 1-844-508-4677 OR CVS Caremark Customer Service at 1-866-341-8561. Requests for early refills will be handled on a case-by-case basis. Vacation fills are limited to 2 vacation overrides per calendar year.
  - Plan members who are called to active military duty or members in time of national emergency who need to obtain prescribed medications should call True Health New Mexico Customer Service at 1-844-508-4677.
- **We use prior authorization, step therapy, and quantity limit processes.** Our formulary will have the below initials below next to medications that require each process.
  - **Prior Authorization (PA)** is a process we use to determine medical necessity for certain medications. The PA process helps us ensure that the right medication is delivered at the right time, in the right setting, and to the right patient.
  - **Step Therapy (ST)** is a tool used to control costs for certain drug types as well as ensure quality and safety. If you have a new prescription for certain kinds of medications, you must first try the most cost-effective (first-line) drug in that category before another one is covered. In most cases, the cost-effective drug will work for you, but if it doesn't, your prescriber will need to request prior authorization for another (second-line) drug in the same category. If you are currently taking a second-line drug and your prescriber has submitted a prior authorization request for that drug, you will be able to continue treatment on that drug until we have made a determination.
  - **Quantity Limits (QL):** Some medications have a limited amount that can be covered at one time. If you require more than the quantity limit allows, your prescriber will need to request prior authorization for the additional quantity.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. Not all medications have generic equivalents available. If there is no generic available, you will pay the brand-name copay for the brand-name product.
- **Why use generic drugs?** Generic drugs have the same active ingredients as their brand-name equivalents, but cost significantly less. Companies that make generic drugs do not have to invest large amounts of money in research, since the company that makes the brand-name product has already done this. Also, generic companies do not need to advertise their drugs and can pass the savings on to consumers. The FDA regulates generic drug manufacturers just as it regulates makes of brand-name medications. The generic drug must pass strict FDA requirements to ensure that it delivers the same amount of active ingredient in the same time frame as the brand-name equivalent.

- **$0 Generic Drug List:** We cover generic drugs no cost for certain medications used to treat asthma, bipolar disorder, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, depression, diabetes, hypercholesterolemia, and hypertension. For the complete list, please visit our website, www.truehealthnewmexico.com/federal-employees.
- **When you do have to file a claim.** If a pharmacy cannot process your prescription claim, you may be asked to pay the full price of the medication. If that happens, you can submit a direct reimbursement paper claim form to:

  CVS Caremark - RxClaim
  P.O. Box 52136
  Phoenix, AZ 85072-2136

  OR

  You can call CVS Caremark Customer Service at 1-866-341-8561.

- Paper claims are reviewed to determine member eligibility on the date of service AND for coverage status of the medication. If your paper claim is approved, you will be reimbursed the amount that you paid for the medication, less the appropriate copayment.

| Benefit Description | You pay |
|---|---|
| **Note: The calendar year deductible applies only when we say below: "after the deductible".** | |
| **Covered medications and supplies** | **High Option** |
| We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:<br>• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.*<br>• Oral oncology medications<br>• Insulin<br>• Diabetic supplies limited to:<br>- Disposable needles and syringes for the administration of covered medications<br>- Blood glucose monitors and test strips listed on the formulary<br><br>Note: Blood glucose monitors are also covered under your durable medical equipment benefit. See Section 5(a) Durable Medical Equipment.<br><br>Note: Drugs for IV/Infusion therapy obtained through your provider are covered under your outpatient professional benefit. See Section 5 (a) Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.<br><br>Note: We cover medical foods under your durable medical equipment benefit. See Section 5(a) Durable Medical Equipment. | **Prescription Drugs (Retail) - 30-day supply or less**<br>• Tier 1 (Generic) - $5 copay<br>• Tier 2 (Preferred Brand) - $30 copay<br>• Tier 3 (Non-preferred Brand) - $70 copay<br>• Tier 4 (Preferred Specialty) - $350 copay<br>• Tier 5 (Non-preferred Specialty) - $450 copay<br><br>** Specialty drugs are limited to a 30-day supply or less and must be purchased at CVS/Caremark<br><br>**Prescription Drugs (Maintenance) - 90-day supply, 2x retail copay**<br>• Tier 1 (Generic) - $10 copay<br>• Tier 2 (Preferred Brand) - $60 copay<br>• Tier 3 (Non-preferred Brand) - $140 copay<br>• Tier 4 (Preferred Specialty) - Not covered<br>• Tier 5 (Non-preferred Specialty) - Not covered<br><br>Insulin - $25 copay maximum per 30-day supply purchased at a Retail pharmacy or $50 copay maximum per 90-day supply purchased through Mail Order<br><br>Oral Chemo - $0 copay, must be purchased at CVS/Caremark Specialty Pharmacy |
| Women's contraceptive drugs and devices | Nothing |

*Covered medications and supplies - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Covered medications and supplies (cont.)** | **High Option** |
| Note: Methods of preferred generic oral contraceptives, injectable contraceptives or contraceptive devices. For a complete list of these preferred products, please visit our website at www.truehealthnewmexico.com/federal-employees.<br><br>An emergency contraceptive is covered over-the-counter (OTC) at no cost if prescribed by a physician and purchased at a network pharmacy. | Nothing |
| **Preventative medications** | **High Option** |
| The following are covered:<br>• Aspirin (81 mg) for men ages 45-79 and women ages 55-79 and women of childbearing age<br>• Folic acid supplements for women of childbearing age: 400 and 800 mcg<br>• Liquid iron supplements for children ages 0-1 year<br>• Fluoride tablets, solution (not toothpaste, rinses) for children ages 0-6<br>• Anti-cholesterol agents "statins"<br>• Anastrazole, exemestane, tamoxifen, and raloxifene when used for primary prevention of breast cancer **documentation is required to support primary breast cancer prevention<br>• Bowel preparations for members age 50 years or older<br>• Truvada or generic equivalent for pre-exposure prophylaxis (PrEP) of Human Immunodeficiency Virus (HIV) infection<br><br>Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low-dose aspirin for certain patients. For current recommendations, go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations | Nothing |
| *Not covered:*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Drugs to enhance athletic performance*<br>• *Fertility drugs* | *All charges* |

*Preventative medications - continued on next page*

| Benefit Description | You pay |
|---|---|
| **Preventative medications (cont.)** | **High Option** |
| • *Drugs used to treat sexual dysfunction*<br>• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*<br>• *Nonprescription medications unless specifically listed on the formulary*<br>• *Bulk chemicals used in compounds*<br>• *Compounding kits*<br>• *Drugs or drug combinations not approved by the Food and Drug Administration*<br>• *Personal care items*<br>• *Probiotics*<br>• *Dietary supplements or prescription vitamins (other than prenatal)*<br>• *Medications excluded by regulation as described by the Centers for Medicare & Medicaid Services*<br><br>*Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 37.)* | *All charges* |

## Section 5(g). Dental 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
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan providers must provide or arrange your care.
- The calendar year deductible is: $250 per person ($500 per Self Plus One enrollment, or $500 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.
- 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 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 |
|---|---|
| **The calendar year deductible applies to some benefits in this Section. We added "after the deductible" to show when the calendar year deductible applies.** | |
| **Accidental injury benefit** | **High Option** |
| We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth if:<br>• The need for these services is a result of an accidental injury; and<br>• The tooth has not been restored previously, except in a proper manner; and<br>• The tooth has not been weakened by decay, periodontal disease, or other existing dental pathology.<br><br>Note: We cover these services only when started within ninety (90) days and completed within one (1) year of the accidental injury.<br><br>Note: Please see hospital sections information on hospital or surgical benefits. | $250 copay per visit at an outpatient facility<br><br>$500 copay per inpatient admission |
| **Dental benefits** | **High Option** |
| We have no other dental benefits. | |

## Section 5(h). Wellness and Other Special features

| High Option | |
|---|---|
| **Feature** | **Description** |
| **Flexible benefits options** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• 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.<br>• 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.<br>• By approving an alternative benefit, we do not guarantee you will get it in the future.<br>• 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.<br>• 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.<br>• 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** | If you have a non-life-threatening illness or injury, or if you have questions about symptoms you are having, you may call the Care Connect Nurse Advice Line toll-free at 1-844-308-2552. Experienced registered nurses are available to talk to you 24 hours a day, 7 days a week, 365 days a year. Depending on your needs, a nurse may arrange a telephone consultation with an MDLIVE® doctor. MDLIVE doctors are board-certified in New Mexico and are in the True Health New Mexico provider network. |
| **Health and wellness maintenance and improvement programs** | We offer programs for the purposes of medical management; quality improvement; and behavioral and physical health wellness, maintenance, or improvement over and above the high option Plan benefits. Discount programs for various health and behavioral wellness items and services may also be available from time to time. For details of current discounts or other programs available, call our customer service at 1-844-508-4677 or visit our website at www.truehealthnewmexico.com/federal-employees. |
| **Services for the deaf and hearing-impaired** | Our TTY number for Customer Service is 1-800-659-8331. |

*Feature - continued on next page*

| High Option | |
|---|---|
| **Feature (cont.)** | **Description** |
| **High-risk pregnancy case management** | We offer a voluntary high-risk Maternity Case Management Program to members who qualify. If you choose to take part in this program, we will connect you to a True Health New Mexico maternity case manager. For more information visit our website at www.truehealthnewmexico.com/federal-employees. |
| **Case management and disease management programs** | We offer case management programs to help members and their caregivers with complex medical conditions. In addition, we offer disease management programs for members with certain chronic conditions. For more information, please visit our website at www.truehealthnewmexico.com/federal-employees. |

## 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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3, *When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals 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, 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.
- Travel expenses except for approved out-of-state tissue or organ transplants.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.
- Services provided or arranged by criminal justice institutions for members confined therein.
- Services or supplies we are prohibited from covering under the Federal Law.

# 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 Plan approval), including urgent care claims procedures. When you see Plan providers, 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 1-844-508-4677, or at our website, www.truehealthnewmexico.com/federal-employees.

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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your claims to: True Health New Mexico, Claims Dept., P.O. Box 830955, Birmingham, AL 35283-0955

**Prescription drugs**

Submit your claims to: CVS/Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136

**Other supplies or services**

Submit your claims to: True Health New Mexico, Claims Dept., P.O. Box 830955, Birmingham, AL 35283-0955

**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 health care 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 percent 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 health care 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 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 Customer Service at 1-844-508-4677, or visit www.truehealthnewmexico.com/federal-employees.

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 Department by writing True Health New Mexico, Attn: Appeals and Grievances, P.O. Box 37200, Albuquerque, NM 87176-9914, by calling 1-844-508-4677, faxing 1-800-747-9132, Attn.: Appeal Member-A-and-G@truehealthnewmexico.com.

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 health care 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 his/her 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.

| Step | Description |
|---|---|
| **1** | Ask us in writing to reconsider our initial decision. You must:<br>1. Write to us within 6 months from the date of our decision; and<br>2. Send your request to us at: True Health New Mexico, Attn: Appeals and Grievances, P.O. Box 37200, Albuquerque, NM 87176-9914; or email your request Member-A-and-G@truehealthnewmexico.com; or fax your request to 1-800-747-9132, Attn.: Appeal and Grievance Department.<br>3. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>4. Include copies of documents that support your claim, such as physicians'letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.<br>5. 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.<br><br>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 with 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:<br>1. Pay the claim or |

2. Write to you and maintain our denial or.
3. 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** 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 physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- 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 a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care 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 sue. If you decide to file a lawsuit, 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 1-844-508-4677. 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 dependent 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 health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. 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.truehealthnewmexico.com/federal-employees.

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

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

- **TRICARE and CHAMPVA**

TRICARE is the health care 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 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**

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 a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.
- Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **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 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 on www.benefeds.com/ or by phone at 1-877-888-3337, TTY 1-877-889-5680, 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 trial 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.
- 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. This plan does not cover these costs.
- 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.

**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. To find out if you need to do something to file your claim, call us at 1-844-508-4677 or visit our website at www.truehealthnewmexico.com/federal-employees.

**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 health care professionals.

Please review the following table; it 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 (High Option) | Member Cost without Medicare | Member Cost with Medicare Part B |
|---|---|---|
| Deductible | $250 Self Only/$500 Self Plus One and /$500 Self and Family | $250 Self Only/$500 Self Plus One and /$500 Self and Family |
| Out-of-Pocket Maximum | $6,000 Self Only/$12,000 Self Plus One and /$12,000 Self and Family | $6,000 Self Only/$12,000 Self Plus One and /$12,000 Self and Family |
| Primary Care Physician | $10 copay | $0 in most cases |
| Specialist | $30 copay | $0 in most cases |
| Inpatient Hospital | $500 copay per admission | $0 in most cases |
| Outpatient Hospital | $250 copay | $0 in most cases |
| Rx | Nothing for $0 Drug List drugs<br>Tier 1 - $5 copay<br>Tier 2 -$30 copay<br>Tier 3 - $70 copay<br>Tier 4 – $350 copay<br>Tier 5 - $450 copay | Nothing for $0 Drug List drugs<br>Tier 1 - $5 copay<br>Tier 2 -$30 copay<br>Tier 3 - $70 copay<br>Tier 4 – $350 copay<br>Tier 5 - $450 copay |
| Rx – Mail Order (90-day supply) | 2x retail copay - Speciality not available mail order. | 2x retail copay - Speciality not available mail order. |

- **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 health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

  **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 copayments, 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 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 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**

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.

- 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 cancer, 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

**Copayment**

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 needs that can be performed by non-licensed medical personnel to meet the normal activities of daily living. Examples include but are not limited to bathing, feeding, preparing meals, or performing housekeeping tasks.

**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 page 21.

**Experimental or investigational services**

Experimental or investigational means any treatment, procedure, facility, equipment, drug, device, or supply that is not accepted as standard medical practice in the state where services are provided. In addition, if a federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigational, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies;
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and
- The improvement must be attainable outside the investigational settings.

**Group health coverage**

Health insurance coverage established, offered, and maintained by an employer or by an employee organization that provides medical care for participants or their dependents through insurance, reimbursement, or otherwise.

| | |
|---|---|
| **Health care professional** | A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. |
| **Medical necessity** | Medical necessity refers to healthcare services determined by a provider, in consultation with the carrier, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the carrier consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease. |
| **Plan allowance** | Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. It is the maximum dollar amount that we will consider reimbursing for a covered service or procedure. This amount may not be the amount ultimately paid to the provider because it may be reduced by the coinsurance, deductible, or other cost-sharing amount. |
| **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 of 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. |
| **Us/We** | Us and We refer to True Health New Mexico. |
| **You** | You refers to the enrollee and each covered family member. |
| **Urgent care claims** | 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:<br>• Waiting could seriously jeopardize your life or health;<br>• Waiting could seriously jeopardize your ability to regain maximum function; or<br>• 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.<br><br>Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.<br><br>If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-844-508-4677. 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. |

# Index

# Summary of Benefits for the High Option of True Health New Mexico - 2021

- **Do not rely on this chart alone.** This is a summary. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. Before marking a final decision, please read this FEHB brochure. You can obtain a copy of our Affordable Care Act Summary of Benefits and Coverage at www.truehealthnewmexico.com/federal-employees.
- 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 providers, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $250 calendar year deductible.

| High Options Benefits | You pay | Page |
|---|---|---|
| **Medical services provided by physicians:** | | |
| Diagnostic and treatment services provided in the office | Office visit copay: $10 primary care; $30 specialist | 26 |
| **Services provided by a hospital:** | | |
| • Inpatient | $500 copay per admission | 46 |
| • Outpatient | $250 copay per visit | 47 |
| **Emergency benefits:** | | |
| • In-area | $150 copay per visit | 50 |
| • Out-of-area | $150 copay per visit | 50 |
| **Mental health and substance use disorder treatment:** | Nothing for an office visit; Regular cost sharing for all other services | 51 |
| **Prescription drugs:** | | 54 |
| • Retail | Tier 1 - $5 copay, Tier 2 - $30 copay, Tier 3 - $70 copay, Tier 4 - $350 copay, Tier 5 - $450 copay | 56 |
| • Mail order | 2 times the retail copay - specialty not available via mail order | 56 |
| **Dental care:** | Limited to accidental injury. | 59 |
| **Vision care:** | 10% of our allowable after the deductible for medically necessary services. Nothing for eyeglasses or contact lenses and one eye refraction exam for children under 18 with a VSP provider or 50% of charges with a non-VSP provider. | 33 |
| **Wellness and other special features:** | Wellness Discounts, 24-Hour Nurse Advice Line, High-Risk Pregnancy Case Management, Flexible Benefits Option | 60 |
| **Protection against catastrophic costs** (out-of-pocket maximum)**:** | Nothing after **$6,000/Self Only or $12,000/ Self Plus One and Self and Family enrollment per year** | 21 |

| | | |
|---|---|---|
| | Some costs do not count toward this protection | |

# 2021 Rate Information for True Health New Mexico

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**.

**Non-Postal rates** apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

**Postal rates apply to certain United States Postal Service employees as follows:**

- **Postal Category 1 rates** apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

**Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.**

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution 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 | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| | | Gov't Share | Your Share | Gov't Share | Your Share | Category 1 Your Share | Category 2 Your Share |
| **New Mexico** | | | | | | | |
| **High Option Self Only** | EL1 | $221.22 | $73.74 | $479.31 | $159.77 | $70.79 | $61.20 |
| **High Option Self Plus One** | EL3 | $495.12 | $165.04 | $1,072.76 | $357.59 | $158.44 | $136.98 |
| **High Option Self and Family** | EL2 | $522.39 | $174.13 | $1,131.85 | $377.28 | $167.16 | $144.53 |