



# MEMBER HANDBOOK



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## Welcome

Welcome to US Family Health Plan! We are glad you are a member.

This handbook is a guide to using your health plan. We hope it will answer most of your questions. If not, additional questions should be directed to the Customer Service department at [usfamily@svcmcnyc.org](mailto:usfamily@svcmcnyc.org).

We are your partners in promoting your best quality of health.

## The US Family Health Plan

US Family Health Plan (USFHP) is a TRICARE option within the Military Health System. We are a TRICARE Prime managed care program that provides comprehensive health coverage. We have been providing comprehensive health care for military families and retirees for over 30 years.

Our comprehensive health care benefits are the TRICARE Prime benefits plus many enhanced healthcare services. As a member of US Family Health Plan you will be able to participate in state of the art patient care management programs. We offer comprehensive case management, disease management, 24/7-nurse advice line, and preventative health programs, which are designed to keep you as healthy as possible. We offer personalized and comprehensive care in all of New Jersey, as well as many counties in New York, Pennsylvania, and Connecticut. Our extensive network of highly qualified civilian providers in all service areas gives you freedom to choose!

In addition to TRICARE Prime benefits, USFHP offers retirees additional enhanced benefits: Preventative Dental Services, Gym Reimbursement or Vision Hardware for eligible retirees. More information on pg. 21.



## Member Rights and Responsibilities

You have the following rights and responsibilities as a USFHP member:

- The right to choose the health care provider that is best for you from the Plan's extensive network of highly qualified providers.
- The right and responsibility to fully participate in all decisions related to your health care.
- The right to considerate and respectful communications from all USFHP staff and from all network providers.
- The right to communicate in confidence with all USFHP staff and network providers. You can be assured that your private health information is kept confidential and protected at all times. USFHP adheres to all Federal and TRICARE privacy regulations.
- The right to assume responsibility for your own best health, in partnership with your PCP and USFHP, which will increase the likelihood of achieving your best health outcomes.

## Member Health Care Management

### *Managed Care Approach to Quality Health Care*

An important feature of our managed care approach to your overall health care is providing quality medical care in the setting that is most appropriate for you. For example, care will be provided on an outpatient basis unless inpatient treatment is medically necessary, thus sparing you from the risk of an unnecessary hospitalization.

TRICARE defines medically necessary care as services or supplies provided by a hospital, physician, and/or other provider for the prevention, diagnosis, and treatment of an illness, when those services or supplies are determined to be:

- Services that are offered as part of the USFHP (TRICARE) benefit;
- Consistent with the condition, illness, or injury;
- Provided in accordance with approved and generally accepted medical or surgical practice;
- Not primarily for the convenience of the patient, the physician, or other providers;
- Delivered in the most appropriate health care setting;
- Not exceeding (duration or intensity) the level of care, which is needed to provide safe, adequate and appropriate diagnosis and treatments.

## Primary Care Provider

Another important feature of our Plan is your use of a Primary Care Provider (PCP). Your PCP is responsible for coordinating your care. This includes making recommendations for specialty consultation and/or facility based care. When, and if, your PCP recommends that you need to see a specialist or need admission to a hospital, or any other facility, he or she will refer you to an appropriate provider. We recommend that our members review our provider locator at [www.usfhp.net](http://www.usfhp.net) in order to verify that the provider is participating with the Plan. USFHP, as your health care partner, stands ready to assist whenever necessary.

## State of the Art Member Health Care Management Programs

An important focus of our member care management philosophy is to partner with you and your PCP to maximize the quality and effectiveness of your health care. We offer several state of the art health care management programs. These programs include:

- **Comprehensive Care Management** – Specially trained registered nurses are available to help you and your PCP coordinate your total healthcare needs to make transitions predictable and efficient across all health care settings.
- **Transitional Care Planning** – Makes transitions predictable and efficient across all health care settings. When you are admitted to a hospital, or other inpatient healthcare facility, discharge planning is especially important to a successful post discharge experience and your best level of health. Specially trained registered nurses are available to work with hospital discharge planners to ensure you have a safe and medically appropriate discharge plan based on your individual needs and detailed discharge instructions.
- **Care Coaching and Disease Education** – offered in partnership with our care management program, specially trained registered nurses and other highly qualified healthcare professionals can help you understand and manage your specific health needs in collaboration with your providers
- **Nurse Advice Line** – In non-emergency situations you can contact the US Family Health Plan's 24-hour nurse advice line for assistance from specially trained registered nurses. These nurses, using nationally accepted guidelines, will ask you some questions and recommend a safe plan of action. This service is available 24 hours a day/7 days a week (even on holidays).
- **Preventative Health Screenings** – The USFHP strongly encourages all of its members to get regular preventative health screenings as recommended by your PCP.

## Referrals and Authorizations

### *Referrals*

A referral is your provider's recommendation for you to obtain care from another provider or facility in the USFHP network. Referrals for specialty care can be written on the specially designed USFHP form or on your provider's prescription pad. USFHP will pay for all covered medical services when, and if, your PCP refers you in advance and the service is provided by a network provider.

Referrals help everyone concerned:

- They inform the specialist why you are referred and where to send the consultation report.
- They assure the specialist that your PCP has recommended the care.
- They assure you that your visit with the specialist is financially covered.

Referrals are valid only for the specific services requested. All referrals are valid for six months, or for the number of visits indicated, whichever comes first. First visit must be within sixty (60) days. It is very important that you keep track of the number of visits that you use from your referral. If more visits are needed, you will need to follow-up with your PCP.

There are a few medical services that do not require you to obtain a referral from your PCP. However it is still very important that you select a participating provider for the following services (except emergency room care):

- Behavioral Health
- Emergency Room Care
- Urgent Care
- Eye Exam
- OB/GYN Exam

It is important, and ultimately your responsibility, to stay in the USFHP network of participating providers. If you are not sure that a doctor, hospital, or facility that your PCP has referred you to is in the USFHP network, please visit our website at [www.usfhp.net](http://www.usfhp.net), or contact Customer Service at [usfamily@svcmcnny.org](mailto:usfamily@svcmcnny.org).

Any referral to an out of network provider or facility also requires an authorization. It is your PCP's responsibility to obtain necessary authorizations for recommended out of network care. **Only your PCP or other participating provider can request an authorization for out of network care. Out of network providers cannot initiate an authorization request.**

## **Authorizations**

Authorizations are handled through the Plan's Utilization Review Department using nationally accepted guidelines. Any time an authorization is required; your provider must obtain the necessary approval for you. If an authorization request is denied a letter will be sent to you (the member), the PCP, requesting provider, and the facility to explain why it was denied and how to appeal that decision.

Authorizations are necessary in order for claims to pay correctly. When they are not obtained, claims may be denied and you may get a bill. This process protects you from getting unnecessary care and from getting paperwork and bills. It is important for you to help us in this process of obtaining referrals and authorizations. This process is necessary to ensure efficient use of health care resources and as a result will help to ensure that you get maximum value.

Additionally, the professional credentials of an out of network provider have not been reviewed by the Plan; nor have they agreed to accept USFHP/TRICARE fees. So, if you see an out of network provider without authorization, under the point of service (POS) option you will be responsible for part of the bill.

**Authorizations are not the same as referrals.** There are **two types** of authorizations.

1. An authorization is **approval from the USFHP to use an out of network provider or facility.** The USFHP requires that you obtain most, if not all of your health care from our extensive list of participating provider and facilities. In very rare situations, the USFHP may allow you to use a provider or facility that is not within the USFHP network. All requests for out of network care must be reviewed and authorized by USFHP in advance of the service (with the exception of emergency care and select urgent care services). Your PCP is responsible to contact USFHP to obtain authorization on your behalf to any out of network doctor or facility.
  - a. The Point of Service (POS) option allows you to refer yourself for care and/or go to a non-network provider without an authorization from the USFHP. The POS option applies to office, hospital based clinics, ambulatory surgery facilities, and all behavioral health and drug rehabilitation facilities & providers; however, using this option comes at a price. TRICARE regulations require that if you use this POS option, the USFHP will not deny payment, but will pay the provider 50% of the TRICARE allowable charges, after you have paid an initial deductible. This deductible will only be applied for care received under the POS option and is based on the TRICARE allowable, not billed charges. The deductible is \$300 per enrollment year for an individual, and \$600 for a family. After paying the deductible you would also be responsible for up to 65% of the TRICARE allowable charge. POS is not available for services requiring a medical necessity review (authorization) for participating providers.
2. An authorization is an **approval from USFHP for you to receive certain medical services that your PCP has recommended for you.** These include elective hospital or skilled nursing facility admissions, selected outpatient procedures, and skilled home care services to name a few. This type of authorization is sometimes also referred to as pre-certification or pre-authorization.

Remember, it is your provider's responsibility to initiate all necessary authorization requests, but it is ultimately your responsibility to have the authorization when needed.

## Authorizations

All services below require prior authorization (not an all-Inclusive list).

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Adjunctive dental</li><li>• Arthroscopy</li><li>• Augmentative communication device (ACD)</li><li>• Biofeedback</li><li>• Cardiac rehabilitation</li><li>• Carotid angiography</li><li>• Chelation therapy</li><li>• Coronary angiogram</li><li>• Cosmetic/plastic surgical procedures</li><li>• CT angiography</li><li>• Dental anesthesia and related institutional services</li><li>• Diabetic education</li><li>• Dialysis</li><li>• Electrophysiologic (EP) Study Ablation</li><li>• Endoscopic retrograde cholangiopancreatography (ERCP)</li><li>• Gamma knife radiosurgery</li><li>• Hearing aid and hearing aid services (benefit limited to active duty dependents)</li><li>• Home birth</li><li>• Home Care</li><li>• Home infusion therapy</li><li>• Hospice</li><li>• Hyperbaric Oxygen Therapy</li><li>• Indium Pentetreotide (Octreoscan) Scintigraphy</li></ul> | <ul style="list-style-type: none"><li>• Injectibles, select and covered under medical benefit</li><li>• Laminectomy/microdiscectomy</li><li>• Laparoscopic procedures, select</li><li>• Lithotripsy (except renal lithotripsy)</li><li>• Magnetic Resonance Angiography (MRA)</li><li>• Magnetic Resonance Imaging (MRI)</li><li>• Medical transport, non-emergent</li><li>• Meniscectomy</li><li>• Inpatient mental health/behavioral health</li><li>• NCI trial participation (phase I, II and III)</li><li>• Neuropsychological testing</li><li>• Nutritional therapy infusion</li><li>• Pain management services</li><li>• Percutaneous transluminal coronary angioplasty (PTCA)</li><li>• PET scans</li><li>• Pulmonary rehabilitation</li><li>• Psychological testing</li><li>• Septoplasty/rhinoplasty</li><li>• Single Photon emission Computer Tomography (SPECT)</li><li>• Speech therapy</li><li>• Stereotactic radiosurgery</li><li>• Vertebroplasty</li><li>• Virtual colonoscopy (CT colonoscopy)</li></ul> |
|---|---|

## Covered Services

Your membership with USFHP entitles you to many health care benefits. Since referrals and authorizations can be confusing, the following table is designed to summarize what services require an authorization and/or a referral. You will find more detailed information on each of these covered service categories in the pages after the table.

COVERED SERVICE CATEGORY	REFERRAL	AUTHORIZATION
Inpatient	Elective -Yes Elective -Yes	Emergent -Yes Emergency -Yes (after)
Outpatient Procedures	Yes	Participating providers have a list of outpatient services that require authorization
Ambulatory Surgery	Yes	Participating providers have a list of outpatient services that require authorization
Emergency Room Care	No	No
Urgent Care Facility	No	No
Medical Transportation	Yes – except if an emergency or if requested as part of an inpatient hospitalization	Yes – except if an emergency
Out of Service Area	No	Yes – the out of service benefit is limited
Behavioral Health Inpatient	No	Yes
Behavioral Health Outpatient	No	No (when in network)
Durable Medical Equipment (includes prosthetics and orthotics)	Yes – but requires prescription	Yes – depends on the item prescribed
Medical Supplies	No, but requires prescription	Yes – if out of network
Laboratory	No, but requires prescription	No- for standard Yes- for specialized
Outpatient Physical and Occupational Therapy	Yes, requires prescription	Yes – after the initial evaluation
Radiology, diagnostic	Yes – also requires prescription	Yes – some radiology services require authorization; your provider has a complete list

## Inpatient Services

Inpatient services generally include medical services provided in an acute care hospital, skilled nursing facility, or rehabilitation facility. **All elective or scheduled inpatient admissions must be pre-authorized 7 days in advance of the intended service date by your PCP or authorized specialist.** Emergency admissions are reviewed for medical necessity after the admission; in case of a medical emergency you do not need to obtain a referral or pre-authorization. If an elective inpatient service is not available at a USFHP network facility, or you have an emergent admission at an out of network facility, USFHP will work with you, your PCP and the facility to meet your needs. USFHP must provide pre-authorization for you to receive inpatient services at an in or out of network facility for all elective or scheduled care.

Co-payments may be required for inpatient admissions. Refer to the Summary of Benefits.

## Outpatient Services

Outpatient services always require a referral and/or a prescription from your PCP and, depending on the procedure, may also require an authorization; we recommend that you specifically ask your PCP. If unsure, please contact USFHP Customer Service by email at [usfamily@svcmcnyc.org](mailto:usfamily@svcmcnyc.org).

Covered outpatient services include:

- Office visits to your PCP.
- Office visits to all specialists to whom your PCP refers you to.
- Preventative health services
  - a. Newborn and well child care for babies up to age 24 months (except when the mother is an unmarried dependent)
  - b. Well child care and well adult care, such as immunizations and annual physicals
- Diagnostic tests including laboratory procedures, and radiology (i.e. EKG and x-ray, etc.)
- Surgical procedures that do not require hospitalization
- Maternity Care
- Treatment of behavioral disorders (with a medical diagnosis) and outpatient alcohol and chemical detoxification and outpatient rehabilitation treatment.
- Physical, occupational and speech therapies
- Hospice Care
- Skilled Home Care

Co-payments may be required for outpatient services. Refer to the Summary of Benefits

## **Ambulatory Surgery Services**

Members can use any participating hospital or participating ambulatory surgery center. Some ambulatory surgery procedures require that your doctor get pre-authorization from USFHP even though the procedure is being performed at participating hospital. Contact the Customer Service department for assistance at [usfamily@svcmcnyc.org](mailto:usfamily@svcmcnyc.org). Ambulatory surgical procedures may be performed at an out of network facility if there is not a participating facility near your home, or if your network doctor generally performs the procedure elsewhere.

However, if performed in an out of network facility ALL ambulatory surgical procedures require pre-authorization from USFHP.

Co-payments may be required for ambulatory surgery. Refer to the Summary of Benefits.

## **Emergency Care Services**

In the event of an emergency, call 911 or go to the nearest hospital and/or medical facility for treatment. A medical emergency is a situation that requires immediate intervention to prevent the loss of life, limb, sight, or body tissue, or to prevent undue suffering. In an emergency, care cannot be safely postponed while you contact your PCP and/or a doctor on call.

Emergency room treatment for a condition that meets this definition does not have to be authorized by your PCP prior to obtaining services and does not have to be provided at a USFHP facility. You are not required to obtain pre-authorization for emergent care. Remember, emergency dental care (with very few exceptions) is not a covered USFHP/TRICARE benefit.

Schedule an appointment with your PCP promptly after discharge and make sure that all follow-up care is obtained within the network, or that your PCP obtains an authorization for additional out of network care. It is always best to call your PCP soon after an emergency room visit or unplanned admission to a hospital.

If you happen to require inpatient hospitalization at an out-of-network facility as a result of an emergency room visit, a hospital staff member will call the USFHP Utilization Review department shortly after your admission. A network provider must provide post-hospital care, or an authorization must be obtained by your PCP for an out of network provider in order for the claim to be paid efficiently. A call to your PCP is always a good idea following an unplanned admission. The USFHP will generally provide an out of network provider with an authorization for you to obtain short-term post-hospital follow-up care with the treating physician. However, you must quickly return to a network provider.

Co-payments may be required for emergency care. Refer to the Summary of Benefits.



### **Urgent Care Services**

It's hard to predict when or where accidents, injuries, or sudden onset of an illness may occur. But you may find yourself in situations that require urgent, but not emergent, medical attention, such as spraining your ankle during an afternoon jog.

Urgent care is defined as health services that are required within 24 hours after the onset of illness or accidental injury which is not life threatening. Unlike an emergency, urgent medical situations can safely wait until you can call your PCP, the USFHP Nurse Advice Line, or speak with a doctor for instructions as to what you should do.

The USFHP Nurse Advice Line is available 24-hours a day 7 days a week at 1-800-241-4848. At any time you can speak to a medical professional who will evaluate the urgency of your medical needs and instruct you how to proceed based on nationally accepted standards of care. If an authorization is required, they can assist.

Co-payments may be applicable for emergency and urgent care services. Refer to the Summary of Benefits.

USFHP will cover care provided at any urgent care facility anywhere In the US.

### **Medical Transportation**

Emergency medical transportation, usually ambulance, is a covered benefit. It does not require authorization from USFHP or referral from your PCP. Non-emergency medical transportation, usually ambulette, is not a covered TRICARE benefit. In limited situations (i.e., transfer from one facility to another facility), USFHP may authorize non-emergency medical transportation. The facility or your PCP is responsible to request authorization for non-emergency medical transportation.

Co-payments may be applicable for medical transportation services. Refer to the Summary of Benefits.

## When You Travel - Out Of Area Coverage

When you are outside of the USFHP service area, USFHP will cover emergency and urgent services provided by licensed physicians and hospitals on an outpatient or inpatient basis. Urgent care that is not provided by an emergency room or a free-standing urgent care center must be authorized by USFHP. Please note, the Nurse Advice Line staff cannot help you locate a provider out of area.

Emergency services, including prescriptions, provided outside of the USFHP network of facilities/service area are not generally covered if the need for care could have been foreseen before leaving the service area.

Healthcare services that are part of an established and active medical treatment plan may be covered out of the Plan's service area. Members who are in the process of an established and active treatment plan for an acute or chronic medical problem may also require medical care, as part of the active treatment plan, while temporarily out of the Plan's geographic service area. Examples of healthcare services included in an active treatment plan of care for an acute or chronic medical problem include lab work or diagnostic radiology. Discuss your needs with your PCP to identify resources and to work with the Plan's utilization review department to obtain pre-authorization.

**There is no out-of-area coverage for routine or elective healthcare services.**

Before traveling out of the area, check your medication supply. See how much you have left before leaving the service area (i.e., last pill, last shot of insulin). Do not wait until your last dose of medication. Obtain a refill, if you can, before you depart.



SUMMARY OF BENEFITS

**Summary of Benefits and Co-Payments**

COVERED SERVICES	Active Duty Family Members	Retirees with Medicare Part B	Retirees without Medicare Part B
<b>Outpatient Services (Fees are subject to change)</b>			
Office Visits	\$0	\$0	\$20-PCP/\$31 Specialist
Maternity Care (prenatal, postnatal)	\$0	\$0	\$0
Well-baby care (up to age 6)	\$0	\$0	\$0
Annual well-child care (age 6 and older)	\$0	\$0	\$0
Annual physical examination	\$0	\$0	\$0
Ambulatory surgery and procedures (including anesthesia)	\$0	\$0	\$62
Physical, occupational, speech therapy	\$0	\$0	\$31 per visit
<b>Inpatient Services (Fees are subject to change)</b>			
Semi-private room and board	\$0	\$0	\$156 per admission
Physicians services	\$0	\$0	\$0
General nursing services	\$0	\$0	\$0
Diagnostic tests, including lab and x-ray	\$0	\$0	\$0
Operating room, anesthesia and supplies	\$0	\$0	\$0
Medically necessary supplies and services	\$0	\$0	\$0
Physical therapy	\$0	\$0	\$0
<b>Mental Health Service (Fees are subject to change)</b>			
Outpatient care: individual	\$0	\$0	\$31 per visit
Outpatient care: group	\$0	\$0	\$31 per visit
Partial hospitalization mental health	\$0	\$0	\$156 per admission
Inpatient hospital psychiatric care	\$0	\$0	\$156 per admission
<b>Substance Abuse Treatment (Fees are subject to change)</b>			
Outpatient – group therapy	\$0	\$0	\$31 per visit
Inpatient service	\$0	\$0	\$156 per admission
Inpatient rehabilitation	\$0	\$0	\$156 per admission
<b>Other Services (Fees are subject to change)</b>			
Medical Transportation service (when medically necessary)	\$0	\$0	\$41 per occurrence
Durable medical equipment (including orthotics and prosthetics) and medical supplies	\$0	\$0	20%
Emergency room services <sup>1</sup>	\$0	\$0	\$62 per visit
Eye examinations (1 per enrollment period)	\$0	\$0	\$0 per visit
Radiation/chemotherapy office visits	\$0	\$0	\$31 per visit
Skilled nursing facility care (when medically necessary)	\$0	\$0	\$31 per day
Home healthcare (part time skilled nursing care)	\$0	\$0	\$0 per visit
Out of area (emergency room)	\$0	\$0	\$62 per visit
<b>Pharmacy (over the counter medications are not covered) (Fees are subject to change)</b>			
Prescriptions drugs (up to 30 day supply) <sup>2</sup> (up to 30 day supply) <sup>2</sup>	\$13 generic/\$33 brand, formulary \$60 brand, non-formulary	\$13 generic/\$33 brand, formulary \$60 brand, non-formulary	\$13 generic/\$33 brand, formulary \$60 brand, non-formulary
Mail order pharmacy drugs (up to 90 day supply) <sup>2</sup>	\$10 generic/\$29 brand, formulary \$60 brand, non-formulary*	\$10 generic/\$29 brand, formulary \$60 brand, non-formulary	\$10 generic/\$29 brand, formulary \$60 brand, non-formulary*
Yearly Enrollment Fee	\$0	\$0	\$300 per individual \$600 per family

Note: Out of network services without an authorization may be subject to POS.

1. Unless you are admitted to the hospital, in which case only the inpatient co-pay applies.
2. Prescription drug availability is limited to those prescribed by a licensed provider and covered as a Plan benefit.

Availability of non-emergency prescriptions when out of area is also limited. Over the counter medications and supplies are not covered.

Co-payments, Co-insurance and Enrollment fees are subject to TRICARE Defense Health Agency (DHA) changes. For the most updated information, please visit our webpage [www.usfhp.net](http://www.usfhp.net).

### Service Limitations and Exclusions

USFHP, according to TRICARE policy, cannot provide coverage (payment) for the following general services:

<ul style="list-style-type: none"> <li>• Services provided or charges incurred prior to, or after, the effective date of coverage under the Plan</li> <li>• Services not specifically included as a TRICARE benefit</li> <li>• Care or treatment as a result of being engaged in an illegal occupation or commission of, or attempted commission of, a felony or assault</li> <li>• Charges or services for which you or your covered dependent(s) are not legally required to pay, or that would not have been made if coverage had not existed</li> <li>• Charges for missed appointments, telephone consultations, or the completion of medical reports or certification services</li> <li>• Services and drugs not prescribed or authorized by your primary care provider (PCP) or a specialist to whom you were referred, unless using the POS option.</li> </ul>	<ul style="list-style-type: none"> <li>• Services provided by people who ordinarily reside in your household, or the household of your covered dependent or who are related by blood, marriage, or legal adoption to you or your covered dependent</li> <li>• Services not considered medically necessary for your diagnosis; and, treatment provided at an inappropriate level</li> <li>• Services that are experimental/ investigational, or of a research nature</li> <li>• Any services provided for education, employment, licensing, immigration, elective travel, or other administrative reasons</li> <li>• Any services provided by an unlicensed provider or a provider who is not a TRICARE authorized provider type</li> <li>• Complications due to a non-approved, or non-covered, procedure</li> <li>• Care which is custodial in nature</li> </ul>
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According to TRICARE policy USFHP cannot provide coverage for the following specific services (this list is not all-inclusive and subject to change):

<ul style="list-style-type: none"> <li>• Acupuncture and acupressure</li> <li>• Artificial insemination, in vitro fertilization, and other therapies (including drug therapy) to induce pregnancy</li> <li>• Autopsy and postmortem exams</li> <li>• Bed wetting correctional devices</li> <li>• Breast implants for cosmetic services or removal of breast implants if obtained for augmentation or cosmetic reasons</li> <li>• Aversion therapy in connection with alcoholism</li> <li>• Cosmetic, plastic, or reconstructive surgery not connected to medical treatment</li> <li>• Custodial care</li> <li>• Dental care</li> <li>• Dentures</li> <li>• Education or training</li> <li>• Electrolysis</li> <li>• Experimental or investigational treatment and procedures (limited exception)</li> <li>• Food, food substitutes or supplements, and vitamins consumed outside a hospital, except for home parenteral/ nutrition therapy</li> <li>• Foot care, except in connection with medical treatment (routine foot care is covered only for enrollees with specific medical conditions, such as diabetes)</li> <li>• Genetic tests not ordered by your PCP and under certain other conditions</li> <li>• Hearing aids (limited exceptions)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing examinations, except in connection with medical or surgical treatment of a covered illness or injury</li> <li>• Immunizations for elective travel</li> <li>• Learning disorder treatments, including dyslexia</li> <li>• Chiropractic services</li> <li>• Massage therapy</li> <li>• Megavitamins and orthomolecular psychiatric therapy</li> <li>• Mind expansion</li> <li>• Naturopathic service</li> <li>• Orthodontia</li> <li>• Orthopedic shoes and arch supports, except when a part of a brace - orthotics (limited exceptions)</li> <li>• Over the counter drugs or vitamins or food supplements</li> <li>• Private hospital rooms, unless ordered by the attending physician for medical reasons, or if a semiprivate room is not available</li> <li>• Radial keratotomy</li> <li>• Respite care (limited exception)</li> <li>• Retirement home, assisted living facilities, domiciliary homes</li> <li>• Sex change procedures</li> <li>• Sterilization reversals</li> <li>• Telephone services or advice including remote monitoring and consultation, except for trans-telephonic monitoring of pacemakers</li> <li>• Transportation for convenience</li> <li>• Visual training</li> </ul>
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## Pharmacy Benefit

The USFHP pharmacy benefit manager is Maxor Plus. MaxorPlus assists US Family Health Plan in the management of the pharmacy benefit.

Prescription drugs are covered by USFHP when ordered by a licensed provider and when obtained from a Maxor pharmacy or from Maxor mail order. Acute medications, like antibiotics, and the initial prescription for non-urgent medications may also be obtained at a participating network pharmacy. The medications must be approved by the Food and Drug Administration (FDA), be medically necessary for the condition being treated, and must abide by all TRICARE Uniform Formulary regulations and policies. The TRICARE Uniform Formulary covers most FDA approved prescription medications at one of 3 levels of co-payment.

Medications that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness are not covered by TRICARE (USFHP). The Department of Defense (DoD) Pharmacy & Therapeutics Committee recommends medications for the Uniform Formulary and the Director, TRICARE Management Activity (DHA), makes the final decision.

TRICARE (USFHP) has a mandatory generic substitution policy. If a brand name medication has a generic equivalent, it is DOD policy to dispense the generic equivalent instead of the brand name medication. The brand name medication may be dispensed only if the USFHP determines that it is clinically required for you to use the brand name instead of the generic. Maxor will initiate a request for clinical justification from your provider when it is necessary. The information will be reviewed. In non-emergent situations it generally takes 2-3 days for your provider to respond and a decision made. Only a physician can determine if a medication cannot be justified. You or your provider can appeal any denial to the USFHP. At times it may be necessary for you to discuss the use of brand versus generic with your provider.

TRICARE (USFHP) has pre-authorization requirements for some medications. Some drugs may require your provider to submit a special pre-authorization form. TRICARE has set the medical necessity criteria that must be met prior to dispensing. In order to minimize inconvenience, Maxor will send this form to any provider who orders such a medication; in non-emergent situations it generally takes 2-3 days for your provider to respond and a decision made. Only a physician can determine if a medication cannot be justified. Any denial can be appealed to the USFHP by you or your provider. A copy of the pharmacy pre-authorization form is available to your provider on the Plan's website ([www.usfhp.net](http://www.usfhp.net)); only licensed providers may initiate and submit this form for review.

**TRICARE (USFHP) also has quantity limitations:**

- You may obtain up to a 90-day supply through Maxor Mail Order or at a Maxor pharmacy located at the Fort Wadsworth Family Health Center (Staten Island, NY) or the Mitchel Field Family Health Center (Garden City, NY).
- You may obtain up to a 30-day supply at a Maxor participating local retail pharmacy for urgent, or initial non-urgent medications.
- The amount of medication dispensed is limited to the amount of medication expected to be used in a 90-day or 30-day period based on the directions for use on the prescription.
- Some medications have more stringent quantity limitations.

Quantity limits are applied by the DOD to address overuse of medications that can be unsafe for the patient and costly to the government. The USFHP will make exceptions to quantity limits if the prescribing provider is able to justify medical necessity. A copy of the quantity limit override request form is available for your provider at our website ([www.usfhp.net](http://www.usfhp.net)); only licensed providers may initiate and submit this form for review.

MaxorPlus is available to assist with TRICARE Uniform Formulary and other clinical questions. Routine refills of most covered prescription medications can be obtained from Maxor Mail Order Pharmacy. Maxor pharmacies are also conveniently located at two of the Plan's Family Health Centers. In addition, many national and local pharmacies are in the Maxor network for acute medications. Please visit our website at [www.usfhp.net](http://www.usfhp.net) (pharmacy benefits page) to locate a Maxor network pharmacy in your area.

**Maxor Pharmacy at Fort Wadsworth**  
(Staten Island, NY)

- 718-273-4260 (phone)
- 718-816-5830 (fax)
- Current pharmacy hours:
  - Monday 9:00 am – 6:00 pm
  - Tuesday 9:00 am – 5:00 pm
  - Wednesday 9:00 am – 5:00 pm
  - Thursday 9:00 am – 5:00 pm
  - Friday 9:00 am – 4:00 pm

**Please note that pharmacy hours are subject to change based on physician/office schedule. Always call ahead to make sure the pharmacy is open.**

- Members may obtain 90-day supply of covered prescription medications at this location.

**Maxor Pharmacy at Mitchel Field**  
(Garden City, NY)

- 516-222-0401 (phone)
- 516-222-0672 (fax)
- Current pharmacy hours:
  - Monday 8:30 am – 4:30 pm
  - Tuesday 10:00 am – 6:00 pm
  - Wednesday 8:30 am – 4:30 pm
  - Thursday 8:30 am – 4:30 pm
  - Friday 8:30 am – 4:30 pm

**Please note that pharmacy hours are subject to change based on physician/office schedule. Always call ahead to make sure the pharmacy is open.**

- Members may obtain 90-day supply of covered prescription medications at this location

Co-payments are required on prescriptions, and the amount will depend on whether the drug is 1st Tier (generic), 2nd Tier (formulary name brand), or 3rd Tier (non-formulary). The co-payment for generic prescriptions are \$11, formulary name brand prescriptions are \$28, and prescriptions for TRICARE non-formulary medications are \$53. This fee will cover up to a 30-day supply when filled by a participating pharmacy.

For ongoing medication filled through **Maxor Mail Order**, the co-payment for generic prescriptions are \$7, formulary name brand prescriptions are \$24, and prescriptions for TRICARE non-formulary medications are \$53. This fee will cover up to a 90-day supply when filled through Maxor Mail Order or at our Mitchell Field or Ft. Wadsworth Health Center Maxor Pharmacies. When non-formulary medication is ordered Maxor will initiate a request from your provider for any information your provider can supply that will justify the non-formulary drug and a \$53 copay will apply. When medical necessity can be determined future co-payments will be at the lower rate. Mail order is mandatory for all routine prescriptions refills, and some non-urgent medications. Always remember to call Maxor Plus at the number on your membership card should you feel it is necessary to obtain routine drugs from a local pharmacy.

The TRICARE Pharmacy & Therapeutics Committee meets quarterly and makes changes to the formulary status and co-payments. If you are taking medication that change, the USFHP/Maxor will notify you and your provider before the change takes effect.

### **How to get prescriptions filled:**

*New or urgent, short-term acute medications* for 30 days or less, and oral antibiotics: Present your prescription and member ID card at a Practice Maxor Pharmacy, a participating Maxor Retail Pharmacy; or use mail order.

### **Maintenance medications for 31 days or more:**

USFHP **requires** members to fill maintenance medications through a Maxor pharmacy (conveniently located at Mitchel Field or Fort Wadsworth) or Maxor Mail Order Pharmacy. When obtaining an initial prescription for a maintenance medication, you may ask that your provider write two prescriptions: one for a 30-day initial supply and one for a 90-day maintenance supply. You may, but are not required, fill the initial 30-day prescription at your local Maxor-participating retail pharmacy. Then you can mail your 90-day prescription or the initial prescription to Maxor Mail Order Pharmacy. Allow 10 days for mailing and make sure that co-payment information is on file. Remember that 75% of your current medication supply must already be used before you can order refills.

Occasionally, members may be told that a medication is not covered. If you are at a Maxor participating retail pharmacy, ask the pharmacist to call Maxor Plus at the telephone number that will appear on their computer screen or that is listed on your member ID card. When a medication, not on the TRICARE Uniform Formulary is requested by a local pharmacy, Maxor Plus always asks the pharmacist to call and explain the situation. If the pharmacist is too busy, call Maxor Plus yourself. Use the telephone number on the back of your USFHP card. Many times the problem can be corrected immediately while you are still in the pharmacy. Almost all prescriptions written in the emergency room or urgent care center may be approved this way. In other non-urgent situations, Maxor Plus may need to contact the prescribing doctor before approval can be given. This service is available 24/7.

Maxor Plus can be reached by phone or fax. The toll free phone number is 1-800-687-0707 and the toll free fax number is 1-866-222-3274.

### **Maxor Plus Customer Service representatives are available:**

- Monday – Friday      9:00 am – 8:00 pm EST
- Saturday              9:00 am – 7:00 pm EST
- Sunday                10:00 am – 6:00 pm EST
- A Maxor Plus pharmacist is always available on-call after routine customer service hours to respond to emergent situations.

Maxor Mail Order pharmacy can be reached by phone, fax, mail or Internet. The toll free phone number is 1-866-408-2459 and the toll free fax number is 1-866-589-7656. Maxor Mail Order pharmacy is only permitted to accept prescriptions that are faxed directly from the prescribing provider's office. Members may fax refill requests. Maxor Mail Order customer service representatives are available Monday – Friday, 8:00 am – 6:00 pm CST (9:00 am – 7:00 pm EST). Members can use the Maxor Mail Order automated system at any time to request refills with the prescription number printed on the label. Refills may also be requested at the Maxor website ([www.maxor.com](http://www.maxor.com)). Prescriptions and refill request may also be mailed to the following address:

USFHP/Maxor Mail Order  
PO Box 32050  
Amarillo, TX79120

Please make sure that your payment information is on file with Maxor Mail Order. Medications cannot be mailed without payment information.

### **Prescription Drug Limitations and Exclusions**

Due to TRICARE restrictions, USFHP will not pay for the following:

- Drugs prescribed for cosmetic purposes including but not limited to drugs used for hair growth or wrinkle reduction
- Food supplements
- Homeopathic and herbal preparations
- Multivitamins (except prenatal vitamins for pregnant women and vitamin with fluoride for children)
- Over the counter (OTC) products or any product purchased without a prescription except insulin and related diabetic supplies
- Compounded medications unless all products are FDA approved, are indicated for your specific reason, no commercial product is available, and you have tried appropriate approved medications
- Any prescription refilled before 75% of a previous filling has been used.

# THE CHOICE IS YOURS!

Your overall health is important to us. It begins with choosing a provider who addresses your health care needs. Our members have a vast network of providers from which to choose, and now they can also choose an enhanced benefit! Effective 1/1/2019\*, retirees and their families can select **one** of the offered enhanced benefit options.\*

<b>Benefit</b>	<b>Provisions</b>	<b>Cost</b>
<b>Davis Vision - Eyeglass Benefit</b>	Eyeglasses/Frames and/or Contact Lenses	\$0
<b>Healthplex - Preventive Dental Services</b>	Oral Evaluation Cleaning Bitewings and Xrays	\$0 \$0 \$0
<b>Gym Membership Reimbursement</b>	Annual reimbursement ➤ \$125 for Individual ➤ \$250 for Family	\$0

\* Benefit begins the first of the month following your 90th day of enrollment. Benefit selections apply to full calendar year.

NEW CHOICE ENHANCED BENEFIT



# Davis Vision plans offer...

## Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

## Convenient Network Locations

A national network of preferred providers throughout the 50 states.

## Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

## Value-Added Features:

- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
<b>FRAMES</b>		
Fashion Frame (from the Davis Vision Collection)	\$125	\$0
Designer Frame (from the Davis Vision Collection)	\$175	\$15
Premier Frame (from the Davis Vision Collection)	\$225	\$40
<b>LENSES</b>		
<b>All Ranges of Prescriptions and Sizes</b>	<b>\$90</b>	<b>\$0</b>
<b>Plastic Lenses</b>	<b>\$33</b>	<b>\$0</b>
<b>Oversized Lenses</b>	<b>\$20</b>	<b>\$0</b>
<b>Scratch-Resistant Coating</b>	<b>\$40</b>	<b>\$0</b>
Tinting of Plastic Lenses	\$20	\$15
Polycarbonate Lenses	\$64	\$0 <sup>1</sup> or \$35
Ultraviolet Coating	\$28	\$15
Standard Anti-Reflective (AR) Coating	\$62	\$40
Premium AR Coating	\$80	\$55
Ultra AR Coating	\$113	\$69
Intermediate-Vision Lenses	\$150	\$30
Standard Progressive Addition Lenses	\$154	\$65
Premium Progressives (Varilux® <sup>2</sup> , etc.)	\$248	\$105
High-Index Lenses	\$120	\$60
Polarized Lenses	\$103	\$75
Plastic Photosensitive Lenses	\$123	\$70
Scratch Protection Plan (Single vision   Multifocal lenses)		\$20   \$40

<sup>1</sup> Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

<sup>2</sup> Varilux® is a registered trademark of Societe Essilor International

## Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

**Vision Care Processing Unit**  
**P.O. Box 1525**  
**Latham, NY 12110**

### OUT-OF-NETWORK REIMBURSEMENT SCHEDULE

Eye Examination up to \$40 | Frame up to \$50  
 Spectacle Lenses (per pair) up to:  
 Single Vision \$40, Bifocal \$60, Trifocal \$80, Lenticular \$100  
 Elective Contacts up to \$80, Medically Necessary Contacts up to \$225



## Fashion Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

### Paid-in-full eye examinations and eyeglasses!

*Frame Collection:* Your plan includes a selection of designer, name brand frames that are completely covered in full.<sup>1/1</sup>

**One-year eyeglass breakage warranty included on plan eyewear at no additional cost!**

### How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at [davisvision.com](http://davisvision.com) and click "Find a Provider" to locate a provider near you including:



### IN-NETWORK BENEFITS

<b>Eye Examination</b>	Every 12 months, <b>Covered in full</b>
<b>Eyeglasses</b>	
<b>Spectacle Lenses</b>	Every 12 months, <b>Covered in full</b> For standard single-vision, lined bifocal, or trifocal lenses
<b>Frames</b>	Every 24 months, <b>Covered in full</b> Any Fashion frame from Davis Vision's Collection <sup>1/1</sup> (value up to \$125)  OR \$100 retail allowance toward any frame from provider, plus 20% off balance
<b>Contact Lenses</b>	
<b>Contact Lens Evaluation, Fitting &amp; Follow Up Care</b>	Every 12 months  Non Collection Contacts: Standard Contacts: 15% discount Specialty Contacts <sup>3/3</sup> : 15% discount
<b>Contact Lenses (in lieu of eyeglasses)</b>	Every 12 months  \$100 retail allowance toward provider supplied contact lenses, plus 15% off balance

### ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS

<b>MOST POPULAR OPTIONS</b> <small>Savings based on in-network usage and average retail values.</small>	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	\$40	\$0
Polycarbonate Lenses	\$64	\$0 <sup>3/3</sup> -\$35
Standard Anti-Reflective (AR) Coating	\$62	\$40
Standard Progressives (no-line bifocal)	\$154	\$65
Plastic Photosensitive (Transitions <sup>®/4</sup> )	\$123	\$70

### Lower costs and more benefits! See the savings!

<b>Service</b>	<b>Without Davis Vision</b>	<b>With Davis Vision</b>
Lenses		
Bifocals	\$80	\$0
Scratch-Resistant Coating	\$40	\$0
Transitions <sup>®/4</sup>	\$123	\$70
Frame	\$150	\$0
<b>Total</b>	<b>\$393</b>	<b>\$70</b>

<sup>1/1</sup> The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change.

<sup>2/2</sup> Including, but not limited to toric, multifocal and gas permeable contact lenses.

<sup>3/3</sup> For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.

<sup>4/4</sup> Transitions<sup>®</sup> is a registered trademark of Transitions Optical Inc.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.



Let us give you  
the bright smile  
you deserve!



## Exclusive Dental Benefits Offer for Military Retirees and Their Dependents

### Benefits:

- **No charge** for enrolling
- **No copays** for cleanings, exams and x-rays
- **Deeply discounted** basic, major and orthodontic services\*

\*Discounts will vary depending on where the provider you visit is located.

### Your Savings:

Service	Cost With Healthplex	Estimated Cost Without Healthplex
Oral Evaluation	No Charge	\$100.00
Cleaning	No Charge	\$175.00
Bitewing X-rays	No Charge	\$95.00
<b>Total</b>	<b>No Charge!</b>	<b>\$370.00</b>

It's easy to enroll and coverage can begin as early as **January 1, 2019.**

For questions regarding your benefits, call US Family Health Plan at **212-356-4610.**

# US FAMILY HEALTH PLAN DISCOUNTED FEES

ADA CODE	DESCRIPTION	NY/NJ	Pennsylvania	Connecticut	FairHealth
2160	AMALGAM-THREE SURFACE PRIM/PER	\$75	\$111	\$118	\$350.00
2393	RESIN BASE COMP 3SURF POSTERIO	\$148	\$162	\$171	\$395.00
2720	CROWN - RESIN/HIGH NOBLE METAL	\$525	\$675	\$708	\$1,805.07
2740	PORCELAIN/CERAMIC CROWN	\$425	\$690	\$724	\$1,667.00
2750	PORCELAIN/HIGH NOBLE METAL	\$595	\$681	\$717	\$1,600.00
3110	DIRECT PULP CAP	\$25	\$41	\$44	\$125.00
3220	VITAL PULPOTOMY	\$65	\$99	\$105	\$325.00
3310	ROOT CANAL THERAPY - ANTERIOR	\$350	\$419	\$440	\$1,295.00
3320	ROOT CANAL THERAPY - BICUSPID	\$425	\$512	\$536	\$1,400.00
3330	ROOT CANAL THERAPY - MOLAR	\$500	\$661	\$693	\$1,595.00
3410	APICOECTOMY - ANTERIOR	\$210	\$478	\$503	\$1,400.00
4210	GINGIVECTOMY, PER QUAD	\$180	\$409	\$430	\$700.00
4260	OSSEOUS SURGERY, PER QUAD	\$460	\$778	\$816	\$1,400.00
4341	PERIODONTAL SCALING - QUAD	\$90	\$140	\$148	\$345.00
5110	FULL UPPER DENTURE	\$650	\$905	\$950	\$2,500.00
5120	FULL LOWER DENTURE	\$650	\$905	\$950	\$2,500.00
5213	PARTIAL UPPER - CAST BASE	\$695	\$1,000	\$1,051	\$2,400.00
5214	PARTIAL LOWER - CAST BASE	\$695	\$1,000	\$1,051	\$2,550.00
6210	PONTIC - CAST HIGH NOBLE METAL	\$525	\$597	\$626	
6240	PONTIC - PORC/HIGH NOBLE METAL	\$595	\$589	\$618	\$1,667.00
6250	PONTIC-RESIN HIGH NOBLE METAL	\$525	\$581	\$611	
6720	CROWN-RESIN HIGH NOBLE METAL	\$525	\$656	\$689	
6740	CROWN-PORCELAIN/CERAMIC	\$425	\$593	\$623	
6750	CROWN-PORC HIGH NOBLE METAL	\$595	\$672	\$706	\$1,650.00
7140	EXTRACTION-ERUPTED OR EXPOSED	\$66	\$92	\$97	\$350.00
7210	SURGICAL EXTRACTION	\$110	\$162	\$171	\$550.00
7220	IMPACTION-SOFT TISSUE	\$155	\$183	\$193	\$550.00
7230	IMPACTION PARTIAL BONY	\$188	\$244	\$256	\$550.00
7240	IMPACTION FULL BONY	\$240	\$286	\$300	\$625.00
7310	ALVEOLOPLASTY W/EXTRACT/QUAD	\$62	\$170	\$179	\$750.00
9110	PALLIATIVE TREATMENT	\$30	\$58	\$60	\$200.00
9310	CONSULTATION SPECIALIST	\$50	\$123	\$130	\$225.00

## Network

USFHP has a comprehensive, highly qualified provider network throughout our service area. Every provider in the USFHP network completes an extensive credentialing process, which helps to ensure that you get the very best quality health care. Our provider network consists of:

- **Primary care providers** – doctors and nurse practitioners with specializations in internal medicine, pediatrics, family practice, geriatrics and general practice.
- **Specialty care providers** – all medical specialists including, but not limited to, cardiology, hematology, neurology, oncology, orthopedics, pulmonology, rheumatology, urology, otolaryngology, surgery.

In addition, our provider network is complemented by an extensive list of acute hospitals, ambulatory surgical centers, rehabilitation facilities, skilled nursing facilities, home care and home infusion agencies, just to name a few.

## Behavioral Health Services

Behavioral health issues are common and treatable. Contact your PCP to rule out and/or treat any medical issues. Please contact the USFHP's behavioral health partner, Magellan Health, to get answers to your behavioral health questions. Magellan Health staff can also help you locate a participating behavioral health provider. The nurses and other health care professionals at Magellan Health are available 24 hours per day, seven days a week. All calls are confidential. Call 1-800-241-4848.

Covered behavioral health services include:

- Outpatient individual, group, and family counseling
- Inpatient admissions for behavioral health problems
- Inpatient admissions for alcohol and other substance abuse problems
- Partial hospitalization, intensive outpatient programs, and residential treatment centers

You do not need to obtain a referral from your PCP for outpatient visits with a participating behavioral health provider. You can easily locate a participating behavioral health provider by calling 1-800-241-4848. All other behavioral health services do require referral and authorization. Remember, you must use a participating behavioral health provider.

## **Durable Medical Equipment and Medical Supplies**

Mount Holly Surgical Supplies is the USFHP's preferred provider for most durable medical equipment (DME) and medical supplies. Your provider must prescribe all DME and medical supplies. Examples of covered DME and medical supplies include:

- Ambulatory assistive devices (i.e., canes, walkers, crutches)
- Home respiratory equipment
- Hospital beds
- Lifts
- Prosthetic devices
- Orthotic devices
- Wheelchairs
- Wound care supplies

In addition to a prescription, your provider may need to obtain authorization from USFHP. **Items purchased directly from a pharmacy or from another store are not eligible for reimbursement.**

Co-payments may be required for DME and medical supplies. Refer to the Benefits Summary.

## **Laboratory Services**

LabCorp is our preferred outpatient laboratory services provider. You can go to any LabCorp service center, or participating hospital outpatient laboratory department for ordered laboratory testing. For your convenience in urgent situations you may also have tests done at any other independent lab facility or hospital-based outpatient lab. A referral and/or prescription from your doctor is always required. A list of LabCorp Service Centers is available on LabCorp's website at [www.labcorp.com](http://www.labcorp.com) or by calling LabCorp directly at 1-800-788-9091. There are no co-payments for covered laboratory services. LabCorp requires all patients to supply credit card information at time of visit. Please note that USFHP members will not be billed for any covered services. If you receive a bill please contact Customer Service at 1-800-241-4848.

## **Outpatient Physical and Occupational Therapy**

Outpatient physical and occupational therapy is offered in partnership with OrthoNet. A referral from your provider is required. After the initial evaluation from an OrthoNet participating provider, the therapist is responsible to obtain authorizations for any additional medically necessary services directly from OrthoNet. We recommend all members to verify directly with OrthoNet at 1-800-241-4848 to locate or confirm that a provider is an OrthoNet participant. To minimize your financial liability it is extremely important that you only go to a participating OrthoNet provider.

Co-payments may be required for outpatient physical and occupational therapy. Refer to the Summary of Benefits.

## Radiology Services

You can go to any participating USFHP radiology facility, participating hospital radiology department, or any other radiology facility. A list of participating radiology facilities and participating hospitals is available on our website at [www.usfhp.net](http://www.usfhp.net) or by calling Customer Service at 1-800-241-4848. A referral and/or prescription from your doctor are required for all radiology services. For urgent, plain x-rays, sonograms, ultrasounds, Doppler's or routine mammography, you may go to any local facility. Although an authorization is not necessary, it does help to process the claim. If your provider has recommended an MRI, PET scan or MRA, in addition to giving you a referral your provider must also request an authorization. There are no co-payments for radiology services.

## USFHP Owned Practices

US Family Health Plan currently owns and operates two family health centers in New York; serving only you - military beneficiaries. Our centers proudly provide primary care services to USFHP members. The offices are staffed by board certified physicians, and knowledgeable and friendly clinical and administrative support staff. They have superb patient satisfactions scores, far beyond the military and other civilian health plans. Not only do they provide superb care but they treat you as part of their family, and will assist you with any medical issue, including bills and specialty appointments. Fort Wadsworth offers Internal Medicine, Pediatrics, and Podiatry; and Mitchel Field offers Internal Medicine, OB/GYN and Podiatry. Both perform electrocardiograms, draw blood, provide immunizations, and have a Maxor pharmacy right in the building.

### **Ft. Wadsworth Family Health Center**

206 Drum Road  
Staten Island, NY 10305  
Office: (718) 442-4158  
Fax: (718) 447-1325

#### **Hours of Operations:**

Monday, Tuesday, and Wednesday:  
8:30 am - 4:30 pm  
Thursday: 9 am - 5 pm  
Friday: 8:30 am - 4:30 pm

### **Mitchel Field Family Health Center**

Building 19, West Road  
Garden City, NY 11530  
Office: (516) 222-0228  
Fax: (516) 217-6350

#### **Hours of Operations:**

Monday, Wednesday, Thursday,  
and Friday: 8:00 am - 4:30 pm  
Tuesday: 9:30 am - 6 pm

## Military Treatment Facility

As a member of the US Family Health Plan, you are prohibited from using military treatment facilities (MTFs). The only exception to this limitation is if you have an acute medical emergency and the military treatment facility is the closest facility to you. When out of the USFHP service area or out of the country, it may be possible to obtain an authorization.

## Coordination of Benefits (COB)

It is very important to identify yourself as a USFHP member before receiving care from any provider or facility. This is especially important for members who also have Medicare. Please be reminded to present your USFHP card at the beginning of all appointments, when registering at a facility or emergency room, or before beginning any relationship with a health care provider or facility. If you ever lose your USFHP card, please contact Customer Service by email at [usfamily@svcmcnny.org](mailto:usfamily@svcmcnny.org) right away to have a new card sent to you. If you are Medicare eligible, please remind your providers that the USFHP is primary to Medicare (with very few exceptions).

US Family Health Plan and federal law requires that you report any other health insurance you carry when enrolling. TRICARE policy and Federal law require that any medical claims be filed with your primary insurance plan first, before using USFHP funds to pay your medical bills. After your primary health insurance pays, USFHP will pay any eligible balance up to the allowable TRICARE amount.

All healthcare expenses, including prescriptions, covered by USFHP are subject to this Coordination of Benefits (COB) process. Under COB, the commercial health insurance is the primary payer (except prescriptions), and only those expenses not covered by the primary payer are the responsibility of the Plan. Also, you have additional USFHP protection regarding co-payments. You are only responsible for the USFHP co pay even when the commercial insurance co pay is higher.

It is your responsibility to provide USFHP with the correct information and/or assistance that will enable us to coordinate payment for your health care services with any other insurance you may have. If, prior to enrolling in USFHP, you had other health care coverage that is still effective, or qualify for other coverage while you are a member of USFHP, you are required to disclose this information. You should contact Customer Services with this information by email at [usfamily@svcmcnny.org](mailto:usfamily@svcmcnny.org). Make sure you provide all insurance coverage you have when you register for an appointment with a health care practitioner.

When you or your covered family members have other medical coverage, or receive care or services that would also be covered by workers' compensation or automobile medical benefits (including but not limited to personal injury protection, medical payments, USFHP has a legal right to recover some of the costs of your care. The Coordination of Benefits (COB) provision does not deny you any benefits, to which you are entitled, nor does it reduce your benefits; it is intended to ensure that duplicate payments are not made. All the health care expenses covered by USFHP are subject to this provision.

### The COB process for non-pharmacy claims works like this:

- The provider sends a claim to the primary insurance.
- After payment from the primary insurance the provider sends a claim along with the primary insurance explanation of benefits (EOB) to the USFHP.
- USFHP reviews the claim and pays the required amount minus any applicable USFHP co-payment. You are not required to pay any of the primary insurance co-payments or deductibles.



For pharmacy services always use the USFHP pharmacy benefit first. Maxor will then bill the primary insurance if required.

If you change your insurance coverage, or if you obtain commercial insurance coverage after joining the US Family Health Plan, you must report it by contacting the Customer Service Department by email at [usfamily@svcmcnycny.org](mailto:usfamily@svcmcnycny.org) or by phone @ 1-800-241-4848.

If you are 65 or older and are a member of USFHP, you do not lose your entitlement (**USFHP and Medicare not accepting any new members for this program as of October 2012**) to Medicare; nor do you need to dis-enroll from USFHP to join TRICARE for life. You can maintain your enrollment in the USFHP and retain your Medicare entitlement. However, double payment by Federal government - sponsored programs ARE NOT allowed. USFHP members are not allowed to use their Medicare benefit for services covered by the USFHP. Members are not allowed to enroll in Medicare sponsored managed care plans (HMO's) while enrolled in the USFHP. The use of Medicare benefits by a USFHP member for covered services may be a cause for disenrollment from USFHP.

Members may, however, use Medicare for services that are not covered by USFHP, such as chiropractic care.

If you have Medicare Part B and/or other Medicare supplemental insurance (sometimes referred to as "Medigap"), we urge you to retain this coverage due to pre-existing condition clauses, exclusions, and waiting periods often associated with these plans. If you do not enroll when initially eligible, or drop Medicare Part B and you choose to enroll at a later time, you will pay a higher Part B premium and there will be a waiting period before your coverage is effective.

For each individual who has Medicare Part B coverage, there is no annual USFHP enrollment fee and no co-payments for any covered services except for prescriptions.

## USFHP and Medicaid

USFHP (TRICARE) is always primary to Medicaid. Members may, however, use Medicaid for services that are not covered by USFHP, such as custodial care services.

## End Stage Renal Disease (ESRD) and Medicare

Members, regardless of age, diagnosed with End Stage Renal Disease (ESRD) must apply for Medicare coverage. **Once Medicare coverage is established, it will be considered the primary insurance for the member, and USFHP will be the secondary.** Nurses at USFHP will work with you and your providers to coordinate this transition.

## USFHP and Federal Employee Health Benefits Program

Federal Employees may keep their FEHBP coverage while being a member of USFHP. When a member has both USFHP and FEHBP, FEHBP is primary (like commercial OHI).

## USFHP and Third Party Liability

Third Party Liability occurs when illness or injury suffered by a patient was caused by negligence or the intentional act of a third-party. Examples are as follows: automobile accidents, on-the-job injuries, etc.

The USFHP (DOD) is entitled to reimbursement from the liable party as well as any other party legally responsible for indemnifying you (including but not limited to underinsured and uninsured coverage on automobile policies). You, your representative, or beneficiary must execute documents, and do whatever is necessary for the USFHP to exercise its subrogation and assignment rights.

Members must disclose the existence of commercial coverage and any third-party payer to the Plan, when requested.



## Keeping the Plan Updated

Notifying us right away of such changes will ensure that you and your family will continue to receive the appropriate health care coverage. If there are any changes in your residence, phone number or any additions to your family, it is very important that you notify the USFHP immediately of such a change by emailing the Plan at [usfamily@svcmcnyc.org](mailto:usfamily@svcmcnyc.org).

Should you move out of our service area without dis-enrolling, you could become responsible for all medical bills.

New additions to the family must be eligible with DEERS (Defense Eligibility Enrollment Reporting System) before they are eligible for coverage with USFHP. To check the status or to establish eligibility with DEERS, please call 1-800-538-9552. Newborns of member mothers must be enrolled in DEERS and USFHP within 60 days in order to retain coverage with USFHP. Failure to do so will result in financial liability for services.

If and when you have questions about USFHP and the benefits it provides, please feel free to visit our website at [www.usfhp.net](http://www.usfhp.net) or email us at [usfamily@svcmcnyc.org](mailto:usfamily@svcmcnyc.org).

## Open Season

Effective 2019, TRICARE Open Season is the annual period when you can enroll in or change your health plan for the next year. It occurs each fall, beginning on the Monday of the second full week in November to the Monday of the second full week in December.

Outside of TRICARE Open Season, you can enroll in or change enrollment to TRICARE Prime or TRICARE Select following a Qualifying Life Event (QLE).

A QLE is a certain change in your life, such as marriage, birth of a child, or retirement from active duty, which may mean different TRICARE options are available to you. A TRICARE QLE opens a 90-day period for you to make eligible enrollment changes. A QLE for one family member means all family members may make enrollment changes.

## Appeal Rights

As a TRICARE beneficiary, a USFHP member retains all of the extensive appeal rights granted to any TRICARE beneficiary. These rights are extremely valuable and serve to protect your interests. Appeals to the USFHP are simple and straightforward, but when they go to the Defense Health Agency (DHA) they must meet very strict administrative requirements. When necessary, USFHP staff will assist you, or your agent, in submitting appeals to DHA. In most cases an appeal involves two steps. After the initial request for a service has been denied, your first appeal will generally be reviewed by a USFHP physician who was not involved in the original decision. Your 2nd appeal, in response to an unfavorable first appeal decision, will be sent to the TRICARE National Quality Monitoring Contractor for review by another physician. Even after this step you still have the right to appeal directly to DHA.

Medical care services you can appeal include:

- An authorization denial for a service felt to be unnecessary; for example, an MRI, an admission, or the determination that you no longer require admission to a facility.

- An authorization denial for a service felt to be at the wrong level; for example, at a facility versus at home.
- A service denied as experimental or investigational.
- A service denied as not covered by TRICARE; for example, infant head molding helmets, cosmetic surgery (this type of appeal goes directly to DHA).

Medical care services that are not appealable include:

- A decision by your PCP that you don't require a consultation to a specialist or a diagnostic test.
- TRICARE administrative requirements.
- The requirement to use network providers when access standards can be met.
- Amount of the TRICARE allowable payment rates.

However, even in those cases that are not appealable to TRICARE, the USFHP will always review your issue as a complaint.

All medical necessity appeals will be answered in writing, most within 30 days. Expedited appeals will be answered by the USFHP within 3 days. All decisions will be in writing, and if denied, will include the specific medical reason for the denial. When denied, a contact will be provided for more information, and your next level of appeal rights will be explained. In order to protect your right to appeal to DHA it is important to adhere to all of the administrative requirements noted in the letter.

Although not an appeal, it is very important that you send us any collection agency notices or balance bill notices as soon as you get them. If your provider bills you in error, contact the provider to make sure that they have the correct billing address (as displayed on the back of your USFHP ID card). When sending bills or notices to USFHP, add an explanation of the steps you may have taken to resolve these problems.

## **Complaints and Grievances**

USFHP will address all complaints and grievances in an empathetic, efficient, and timely manner. Most verbal complaints are handled over the telephone at the time they are voiced; the majority of the remainder will be addressed within 10 business days. Grievances, which are written complaints, are all addressed within 60 days, most within 10 business days. Grievances are generally responded to in writing, using the same method in which they were sent (letter, fax, or email). It is important to us that our membership remains highly satisfied with our services, so we want to hear from all members when they are dissatisfied with the USFHP. If the answer to a complaint does not adequately address your issue, do not hesitate to ask for a supervisor, director, or our quality manager.

## **Bills and Bill Payments**

As a USFHP member who follows all of the Plan policies and procedures, you will never be responsible for payment of more than your legal co-payment. With a participating provider, this is defined in the USFHP-provider contract. Non-participating providers do not have a contract with the USFHP; the allowable reimbursement is noted in the authorization. Without a proper authorization for a non-network provider, you may be responsible for up to 115% of the CHAMPUS (TRICARE) maximum allowable amount (CMAC).

Most provider offices automatically send bills to their patients, sometimes within days of an appointment. As a knowledgeable USFHP member, you should closely review any bills or correspondence you get from a provider. When it appears that there could be a problem with payment, you should immediately contact USFHP Customer Services at 1-800-241-4848. Additionally, it is not unusual that some physicians want to be paid up-front. As a military beneficiary and member of the US Family Health Plan your in-network providers are prohibited by contract from both up-front charges and balance billing. However, non-network providers are not held to quite the same standard. The most you, as a TRICARE beneficiary, can be held financially liable by any provider is 115% of the TRICARE/CHAMPUS maximum allowable charge (CMAC). One problem with up-front billing is that non-network providers do not know the CMAC rate and want you to pay their customary charges. Paying them the correct TRICARE allowed amount and getting you a full refund becomes nearly impossible. The USFHP will never knowingly send you to a provider who demands an up-front payment. And neither should you ever go to one. Nevertheless, should you ever be in an office that unexpectedly requests full payment, you should call Customer Services immediately at 1-800-241-4848, before payment. Our staff can then explain how your health plan works and attempt to negotiate with the provider. If unsuccessful, it may be necessary to arrange alternative care. Bottom line: never pay up-front. When impossible to avoid, please send proof of payment and an explanation of the events to the USFHP, requesting reimbursement. The USFHP will investigate and reimburse all, or part of your up-front payment.

The USFHP is required to send members Explanation of Benefits (EOB) for all denied claims. If you get a denial EOB that you think is in error, please contact us by phone or in writing. From time to time the USFHP may also send EOB's for all care. These EOB's inform you that the USFHP has paid for care. The USFHP requests that you carefully review these EOB's and inform us of any discrepancy; such as you did not see that provider, or did not receive that service on the listed date. We will then investigate for possible fraud.

We hope this member handbook has been informative and helpful. US Family Health Plan knows that navigating the health care system can be confusing and difficult. Please do not hesitate to email us at [usfamily@svcmcnny.org](mailto:usfamily@svcmcnny.org). Also visit our website at [www.usfhp.net](http://www.usfhp.net) it contains answers to many frequently asked questions.

Again, thank you for allowing us to serve you!

### Important Addresses & Telephone Numbers

<p><b>USFHP</b></p> <p><b>Customer Service</b> 5 Penn Plaza 9th Floor New York, NY10001 1-800-241-4848</p> <p><b>Monday-Friday 9am-5pm</b></p> <p>Website: <a href="http://www.usfhp.net">www.usfhp.net</a></p> <p>Email Address: <a href="mailto:usfamily@svcmcnny.org">usfamily@svcmcnny.org</a></p> <p>Fax: 212-356-4949</p> <p>Nurse Advice Line 800-241-4848</p> <p><b>Behavioral Health</b> 800-241-4848</p>	<p><b>Outpatient Physical Therapy/Occupational Therapy</b> 800-401-0062</p> <p><b>Pharmacy Information:</b></p> <p>Maxor Mail Order phone 866-408-2459</p> <p>Maxor Mail Order fax: 866-589-7656</p> <p>Maxor Plus (TRICARE Uniform Formulary) phone 800-687-0707</p> <p>Maxor Plus fax: 866-222-3274</p> <p><b>Laboratory</b> Labcorp: 800-788-9091</p> <p><b>DEERS 800-538-9552</b></p>
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IMPORTANT CONTACT INFO



### 1 PATIENT INFORMATION

E-mail Address: \_\_\_\_\_

Phone:    -    -

D.O.B.:   -   -

Sex:  Male  Female

Relationship to Cardholder:

Self  Spouse  Child

Maxor will keep this address on file for all orders filled on this account until another address is provided.

For address changes, please call Maxor Mail Order at (866) 408-2459.

### 2 DRUG ALLERGIES & CHRONIC ILLNESSES

Drug Allergies:  None  Codeine  Sulfa  Aspirin  Penicillin  Other \_\_\_\_\_

Severity of Drug Allergies:  Mild  Moderate  Severe  Intolerance  Anaphylaxis

List your over-the-counter medications:

Chronic Illnesses:  Thyroid  High Blood Pressure  Diabetes  Glaucoma  
(Disease States)  Heart Condition  Intestinal Disorders  Lung Condition  Other \_\_\_\_\_

### 3 GENERIC MEDICATION INFORMATION

- In accordance with Texas Pharmacy Law and availability Maxor Pharmacy will always dispense a generic medication with a lower co-payment unless you specify otherwise. Please contact a customer care associate at (866) 408-2459 to advise us of medications that you want dispensed brand-name only. USFHP will usually not pay for brand-name medications without medical documentation and prior authorization outlining medical necessity. By choosing brand-name only medications USFHP members will usually be responsible for the entire cost of the drug or a higher co-payment.

<sup>1</sup>Please refer to the reverse side of this form for further details.

### 4 PAYMENT METHOD

In order to process your prescriptions quickly, please enclose the correct co-payment amount(s). If assistance is needed with calculating co-payment amount(s), please call Maxor Mail Order at (866) 408-2459.

Payment Options:  Check/Money Order  Credit Card

#### Paying By Credit Card?

Visa  MasterCard  Discover  American Express

Credit Card Number:

Expiration Date:

MM/YYYY

Check here to decline keeping credit card information on file at the pharmacy.

Credit card already on file.

X

Signature of Cardholder

Expedited Shipping via UPS (Additional charges will apply)

Note: Expedited shipping will not rush prescription processing.

**Refill your prescription on reverse side.**

## 5 ORDER REFILLS

### Order Refill Prescriptions Here:

Rx Number	Name of Medication	Strength	Doctor's Name	Co-payment

Questions? Call Maxor Mail Order toll-free at (866) 408-2459, Monday-Friday – 7:00 am to 9:00 pm CST  
Saturday – 8:00 am to 6:00 pm CST • Sunday – 9:00 am to 5:00 pm CST

## 6 HOW TO ORDER

### HOW TO ORDER REFILLS

**BY MAIL:** Complete the payment and refill sections, and mail to Maxor Mail Order.

**BY PHONE:** Call toll free (866) 408-2459 and use our automated system to enter the Rx number printed on your prescription label, or speak to a customer service representative during normal business hours.

**BY INTERNET:** You may refill your prescriptions on our website at [www.maxor.com](http://www.maxor.com). Please choose the REFILL PRESCRIPTIONS section under FILLING YOUR PRESCRIPTIONS. You will need your prescription numbers and credit card information available.

### HOW TO ORDER NEW PRESCRIPTIONS

**BY MAIL:** Complete the payment and patient information sections, enclose your new prescriptions, and mail to Maxor Mail Order.

**BY PHONE:** Have your doctor call in new prescriptions to (866) 408-2459.

**BY FAX:** Your doctor can fax new prescriptions to (866) 589-7656. In accordance with Texas law, only your doctor can fax new prescriptions.

## 7 IMPORTANT INFORMATION

<sup>1</sup> The submission of this form, for you or any of your dependents, authorizes the release of all information to the Plan Sponsor, Administrator, or Underwriter, and authorizes the prescription to be filled with the generic equivalent when available and permissible by law, in accordance with your benefit plan requirements. If you request a brand name drug when your doctor permits substitution, you may be responsible for paying the entire drug cost or a higher co-payment. Refer to your plan benefit information for more details or contact a customer care associate at (866) 408-2459.

**Reminder:** You will always be charged the mail order co-pay when you send or transfer a prescription to Maxor Mail Order. To maximize your savings, ask your doctor for a 90 day supply with refills up to one year.

Written information about this prescription has been provided for you. Please read this information before you take this medication. If you have questions concerning this prescription, a pharmacist is available during normal business hours to answer your questions. Please call your pharmacy.

#### Complaints against the practice of pharmacy may be filed with the:

Texas State Board of Pharmacy  
William P. Hobby Building, Suite 3-600  
333 Guadalupe, Box 21  
Austin, Texas 78701-3942 • (512) 305-8000  
To receive a complaint form call  
(800) 821-3205 or (512) 305-8080 if in Austin.  
(recorded information only)  
[www.tsbp.state.tx.us](http://www.tsbp.state.tx.us)

Se la presentado a usted la informacion por escrito sobre esta receta. Favor de leer esta informacion antes de tomar el medicamento. Si usted tiene preguntas tocante a esta receta, estara un farmaceutico disponible durante las horas de negocio para contestar sus preguntas. Por favor llame a su farmacia.

#### Quejas contra la practica de la farmacia pueden ser reportadas al:

Concilio de Farmacia Del Estado De Tejas  
William P. Hobby Building, Suite 3-600  
333 Guadalupe, Box 21  
Austin, Texas 78701-3942 • (512) 305-8000  
Para recibir una forma de queja llame:  
(800) 821-3205 or (512) 305-8080 if in Austin.  
(informacion grabada solamente)  
[www.tsbp.state.tx.us](http://www.tsbp.state.tx.us)

This form is used to order refills or new prescriptions. Please mail this form 14 days in advance before your medication runs out and enclose the appropriate co-payment amount.

# US Family Health Plan

## Notice of Privacy Practices

Effective date: 04/14/2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

US Family Health Plan is committed to protecting the privacy of your personal information. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care providers to maintain the privacy of your medical information and provide you with notice regarding its privacy practices. This notice describes how we may use and disclose information about you in administering your health benefits, and explains our obligations and your rights regarding this information. We share your information only to the extent necessary in order to administer these benefits and comply with the Federal and State laws that govern health care. We will not use or disclose your information for any other purpose without your permission. We reserve the right to make changes in our privacy practices and the terms of this notice at any time. This includes current information on file and any information we may receive in the future, provided such changes are permitted by applicable law. Before we make any significant changes in our privacy practices, we will change this notice and provide a new notice, available upon request. A copy of our current notice will be posted in the reception area of our practice sites and available for your reference through our Corporate Offices. You may also obtain your own copies by accessing our website at [www.usfhp.net](http://www.usfhp.net) or calling Member Services at 1-800-241-4848.

Personally Identifiable Information (PII) and Protected Health Information (PHI) are defined as financial, health or other information about you that is not public. US Family Health Plan obtains this information in order to provide you with health insurance coverage. Protected Health information is further defined as specific information that identifies you and relates to your medical history.

### WHO WILL FOLLOW THIS NOTICE?

The privacy practices described in this notice shall apply to all employees of US Family Health Plan, its affiliates, agents, interns and the agents, employees or assigns of any business associate, conducting business with US Family Health Plan.

### IMPORTANT SUMMARY INFORMATION

**Requirement for Written Authorization:** US Family Health Plan will generally obtain your written authorization before using or sharing your personal information outside of the Plan.

**Exceptions to Written Authorization Requirement:** There are some situations in which US Family Health Plan would not need your written authorization before using or disclosing your personal information. These exceptions are including, but not limited to: exceptions for treatment; payment and business operations; exceptions as required by law; for public health and safety; emergency situations; and where the information is completely or partially de-identified or used as part of a limited data set.

### HOW WE MAY USE AND DISCLOSE YOUR PERSONAL INFORMATION WITHOUT YOUR WRITTEN CONSENT

In order to administer your health benefits, US Family Health Plan may use and disclose personal information about you in the following ways:

**Healthcare Operations:** Your personal information may be used and disclosed to run our normal business operations. This may include: all activities for health benefits administration including coordination of benefits and care management with third parties; preventive health, disease management, case management and care coordination; quality performance measurement, improvement, investigations and oversight; customer service operations; accreditation by independent organizations; government entities and sharing initiatives; pharmacy benefit administration; reinsurance and stop loss activities; fraud, complaints, and appeals investigations; and other general administrative activities.

**Payment:** Your personal information may be used and disclosed when we pay for your covered services. This may include claims payment activities; utilization and medical necessity reviews; eligibility determination; and enrollment fee collection. Explanation of Benefits forms and other information are mailed to the Sponsor on record.

**Treatment:** Your personal information may be used and disclosed to the providers and individuals who care for you. This may include information given to doctors, pharmacies, hospitals, care managers, health care proxy, and other designated individuals, health care providers and facilities.

**Disclosure to Other Covered Entities:** Your personal information may be used and disclosed to other covered entities or business associates for treatment, payment and other specific business operations.

**Disclosures Required by Law:** Your personal information may be used and disclosed as required by law or other public health and welfare need. This may include disclosure to DoD, TMA, Federal, State, Local and other law enforcement officials; to U.S. Department of Health & Human Services; Food and Drug Administration; to industry regulatory agencies; health oversight committees; other government programs; for legal proceedings, in response to a judicial order, court order, subpoena, or grand jury request; to workers compensation agents; organ procurement and tissue donation organizations; to address matters of national security; and to a public or private entity (e.g., the Red Cross) authorized by law or by its charter to assist in disaster relief efforts.

**Disclosures for Public Health & Safety:** Disclosures to public health or other government authorities may be necessary to prevent imminent harm, injury or disability. In certain situations, reporting is mandatory for public health and safety. We are required to report births, deaths, child abuse, elder abuse or neglect, and domestic violence; we are also required to notify persons exposed to a harmful chemical, substance, communicable disease or at risk to contract or spread a disease or condition; and to report adverse reactions to medications or products as required.

**Partially or Completely De-identified Information:** Your personal information may be used and disclosed if we have removed any information that has the potential to identify you, so that the information is "completely de-identified." We may also use and disclose "partially de-identified" personal information about you if the party who will receive the information signs an agreement to protect the privacy of the information as required by state and federal law. Partially de-identified information will not contain any information that would identify you directly (such as your name, street address, social security number, phone number, fax number, email address, website address or license number).

## YOUR LEGAL RIGHTS

US Family Health Plan wants you to know that you have the following rights to access and control your personal information. These rights are important because they will help ensure the personal information that we have about you is accurate. They may also help you control the way we use your information and share it with others.

**Right to Inspect and Copy Your Records:** You have the right to inspect and obtain a copy of any of your health information that is contained in a "designated record set", defined as medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. This is applicable where we maintain such information in our records. We will disclose this information to you unless your physician or other competent medical authority has determined it would be harmful to you. To inspect or obtain a copy of your health information, please submit your request in writing to US Family Health Plan. If you request a copy of this information, we may charge a fee for the cost of copying, mailing and other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you. We will respond to your request for inspection of records within 10 days. We ordinarily respond to requests for copies within 30 days if the information is located within our facility, and within 60 days if it is located off-site or at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the timeframe above to explain the reason for the delay and when you can expect to have a final answer to your request. Under certain limited circumstances, we may deny your request to inspect or obtain a copy of your information.

**Right to Amend Your Records:** If you believe the information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to ask for an amendment and we will proceed to accommodate your request, if the information is kept in our records and it is reasonable to do so. To request an amendment, please write to US Family Health Plan. Your request should include the reasons why you think we should make the amendment. Ordinarily, we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request. You may appeal, in writing any denial to amend your record directly to our Privacy Office.

**Right to an Accounting of Disclosures:** Effective April 14, 2003, you have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections noted in this Notice of Privacy Practices. An accounting of disclosure does not describe the ways that your health information has been shared within and between US Family Health Plan and the entities listed at the beginning of this notice, as long as all other protections described in this Notice of Privacy Practices have been followed. An accounting of disclosures also does not include information about the following:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when your information is overheard by another person passing by);
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal, state or local law enforcement officials or to the federal government for national security and intelligence activities;
- Disclosures made before April 14, 2003.

To request an accounting of disclosures, please write to US Family Health Plan. Your request must state a time period after April 14, 2003 and no more than six (6) years from the date of your request, for the disclosures you want us to include. You have a right to receive one accounting within any 12-month period for free. However, we may charge you for the cost of providing any additional accounting within that same 12-month period. We will notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred. Ordinarily, we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date for when you can expect to receive the accounting. The right to receive this information is subject to the exceptions as noted herein. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or governmental agency has asked us to do so. The right to receive this information is subject to the exceptions as noted herein.

**Right to Request Restrictions and Additional Privacy Protections:** You have the right to request that we further restrict the way we use and disclose your health information for business operations, payment or treatment. To request a restriction or limitation, please write to US Family Health Plan. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply. Please be advised that we will only agree to the requested restriction or limitation if it is reasonable to do so. While we are not required to agree to your request for a restriction or limitation, there are circumstances in which the restriction or limitation may not be permitted by law. Once we have agreed to your request, we will adhere to that restriction or limitation unless you choose to exercise your right to revoke, which must be in writing. This can be submitted at any time but will not affect earlier disclosures. Under certain circumstances, a termination of the restriction or limitation may be required. However, we will not exercise this right without providing notification before doing so.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about your protected health information by alternative means or to alternative locations. For example, you may request that we communicate with you at home instead of work or by U.S. mail only. We will accommodate all reasonable requests whenever possible and will not ask you the reason for your request. To request more confidential communications, please write to US Family Health Plan and indicate the specific location and means by which you would like for us to communicate with you.

**Other Uses, Disclosures & Access:** of Medical Information: Other uses and disclosures of medical information not specified herein, will be made only after obtaining your written authorization. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization, while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except as described in this notice. We will not use or disclose your medical information if that disclosure is prohibited or significantly limited by other applicable federal or state law. Where the applicable state law provides for additional protections, we will act in accordance with these laws and make disclosures pursuant to such.

**Paper Copy of This Notice:** If you receive this notice on our Website or by e-mail, you are entitled to receive a hard copy of this notice. Please contact member services at 1-800-241-4848 to request a copy.

### RIGHT TO FILE A COMPLAINT

If you are concerned that your privacy rights have been violated, or you disagree with a determination regarding your request or records, you may file a complaint with us in writing to:

US Family Health Plan  
Privacy Office  
5 Penn Plaza, 9<sup>th</sup> Floor  
New York, NY 10001

You may also write to the Secretary of the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office will provide you the address upon request.

Please note that we support your right to protect the privacy of your protected health information and will not penalize or retaliate against you in any way for filing a complaint at any time.



*Serving the Families  
that Serve Ours...*



5 PENN PLAZA • 9TH FLOOR • NEW YORK, NY 10001-0567

1-800-241-4848 • [www.usfhp.net](http://www.usfhp.net)