Physicians Plus Insurance Corporation

www.pplusic.com

Customer Service: 800-545-5015

Physicians Plus

2017

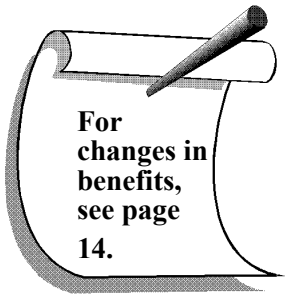
A Health Maintenance Organization (high option) health plan

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

Serving: South Central, Wisconsin, which includes Adams, Columbia, Crawford, Dane, Dodge, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, LaFayette, Marquette, Portage, Richland, Rock, Sauk, Vernon, Walworth, Waukesha, Waushara and Wood counties.

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll.

See page 5 for requirements.



Enrollment code for this Plan:

- **LW1 High Option - Self Only**
- **LW3 High Option - Self Plus One**
- **LW2 High Option - Self and Family**
- **LW4 Standard Option - Self Only**
- **LW6 Standard Option - Self Plus One**
- **LW5 Standard Option - Self and Family**

This Plan has commendable accreditation from the NCQA.

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

Important Notice from Physicians Plus Insurance Corporation About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Physicians Plus Insurance Corporation under our contract (CS 2992) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 800-545-5015 or through our website at www.pplusic.com. The address for Physicians Plus Insurance Corporation's administrative offices is:

Physicians Plus Insurance Corporation
2650 Novation Parkway
Madison, WI 53713

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS)website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Physicians Plus Insurance Corporation.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 545-5015 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

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

Discrimination is Against the Law

Physicians Plus Insurance Plan complies with all applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557, Physicians Plus Insurance Plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy and gender identity).

Preventing Medical Mistakes

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

Take these simple steps:

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.

- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- http://www.jointcommission.org/speakup.aspx.The Joint Commission’s Speak Up™ patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx.The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org.The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org.The Leapfrog Group is active in promoting safe practices in hospitalcare.
- www.ahqa.org.The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

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

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

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/insure/health for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies that participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, and give youbrochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment; • How you can cover your family members; • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire; • When your enrollment ends; and • When the next Open Season for enrollment begins. We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For more information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self Plus One is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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

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

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

Family member coverage

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

Children	**Coverage**
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

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

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2017 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2016 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

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

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

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

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

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

Converting to individual coverage

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

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at (800-545-5015 or visit our website at www.pplus.com.

Health Insurance Marketplace

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

Section 1 How This Plan Works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

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

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

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

General features of our High Option and Standard Option plans

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $7,150 for Self Only enrollment, or $14,300 for a Self Plus One or Self and Family enrollment.

Annual deductible

For the Standard Option: The annual deductible must be met before Plan benefits are paid for care other than office visits, inpatient hospitalization, outpatient surgery, and preventive care services.

No annual deductible for the High Option.

Your rights and responsibilities

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

- Years in existence: 30
- Profit status: For-profit HMO

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

If you want more information about us, call 800-545-5015, or write to Physicians Plus Insurance Corporation, 2650 Novation Parkway, Madison, WI 53713. You may also visit our website at www.pplusic.com.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website Physicians Plus Insurance Company at www.pplusic.com. You can also contact us to request that we mail a copy regarding access to PHI.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: South Central, Wisconsin, which includes Adams, Columbia, Dane, Dodge, Grant, Green, Green Lake, Iowa, Jefferson, Juneau, LaFayette, Marquette, Portage, Richland, Rock, Sauk, Vernon, Walworth, Waukesha, Waushara and Wood counties.

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

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

Section 2. Changes for 2017

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

Changes to Standard Option Only

- DME (page 33) and infertility (page 29) coinsurance does not apply toward deductible and coinsurance limit. However, they still apply toward the catastrophic maximum out-of-pocket.

Changes to High and Standard Options

- The catastrophic out-of-pocket maximum (OOP) (page 20) will increase to $7,150 for Self Only and $14,300 for Self Plus One or Self and Family.
- Federal Employees Wellness Program: wellness incentive for adults (employees and spouses) completing a personal health assessment and biometric screening will change to a $75 limited Visa credit card, which can be used for qualified medical, dental and prescription drug expenses.
- Your share of the non-Postal premium will increase for Self Only and increase for the Self Plus One and Self and Family. See back cover.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-545-5015 or write to us at: Physicians Plus Insurance Corporation , 2650 Novation Parkway, Madison, WI 53713. You may also request replacement cards through our website: www.pplusic.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to NCQA & Physicians Plus Insurance Corporation standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at www.pplusic.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website at www.pplusic.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. When you enroll, you (and your family members) must choose a primary care physician. Each member of your family may select a different primary care physician. Your primary care physician must be a doctor who practices a general scope of medicine. A physician who specializes in only one area of medicine would not be able to treat all of your basic health care needs.

- **Primary care**

Your primary care physician can be any of the following: Family Practice doctors treat people of all ages. They focus on family health problems. General Practice doctors treat people of all ages. Pediatric doctors treat children and adolescents, and generally manage their health. Internal Medicine doctors treat adult men and women. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

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

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

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

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

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

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

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

- **Hospital care**

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

If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-545-5015. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

You must get prior approval for certain services. Failure to do so will result in no coverage.

- **Inpatient hospital admission**

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

- **Other services**

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

- All inpatient services
- Transplants
- All out-of-network provider services
- Non-emergent ambulance transport and elective air ambulance transport
- Durable medical equipment (DME) over $750, CPAP machines, replacement items, continuous glucose monitoring transmitter systems, mechanical stretching devices for contracture or joint stiffness, traction for cervical and lumbar pain, and enteral delivery pumps
- Prosthetics
- Therapies (physical, occupational, speech, habilitative, and home)
- High-tech radiology testing
- Acupuncture
- Genetic testing
- Bariatric surgery
- Skilled nursing care
- Transgender services for hormone therapy

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

First, your physician, your hospital, you, or your representative, must call us at 800-545-5015 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-545-5015. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-545-5015. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

  - You do not need to precertify your normal delivery; see page 9 for other circumstances, such as extended stays for you or your baby.
  - You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.
  - We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.
  - We pay hospitalization and surgeon services (delivery) for non-maternity care the same as for illness and injury.

- **If your treatment needs to be extended**

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

- **To reconsider a non-urgent care claim**

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4 Your costs for covered services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayment	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $15 per office visit, and when you see a specialist you pay a copayment of $25 per office visit.
Deductible	A deductible is the amount of covered expenses that you or your family must pay each year before we will pay for covered expenses. The deductible is applied to your catastrophic out-of-pocket maximums. The High Option Plan does not have a deductible. The Standard Option has a $500 individual deductible (Self Only) and a $1,000 deductible (Self Plus One and Self and Family) for certain services (such as ambulance, diagnostic testing, high-tech radiology, oral surgery, home health services, etc.). Under the family and Self Plus One deductible, no member will ever be required to satisfy more than the individual deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. For the Standard Option, coinsurance does not begin until you have met your calendar year deductible. Example: You pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.
Deductible and Coinsurance Maximum	Includes deductible and coinsurance amounts for certain services you are required to pay when a covered service is provided. Medical copays and pharmacy expenses are not included.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance total $7,150 for Self Only, or $14,300 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services: • Dental Discount benefits • Expenses for services and supplies that exceed the stated maximum dollar or day limit • Expenses from utilizing out-of-network providers Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Carryover

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

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

When Government Facilities Bill Us

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

Section 5. High and Standard Option Benefits

See page 14 for how our benefits changed this year. Page 74 is a benefits summary. Make sure that you review the benefits that are available under the option in which you are enrolled.

High and Standard Option Overview

This Plan offers a High and Standard Option. Our benefit packages are described in Section 5.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 800-545-5015 or on our website at www.pplusic.com.

- All UW Health providers and facilities are now part of the Physicians Plus provider network, including UW Hospital and Clinics and American Family Children's Hospital.
- A Service Area that includes the following counties: Adams; Columbia; Dane; Dodge; Grant; Green; Green Lake; Iowa; Jefferson; Juneau; LaFayette; Marquette; Portage; Richland; Rock; Sauk; Vernon; Walworth; Waukesha; Waushara; and Wood.

High Option Overview

- $0 Deductible
- $15 primary care provider office copayment ($0 for children under 18 years of age)
- $25 specialist office copayment ($0 for children under 18 years of age)
- $25 urgent care copayment
- $100 emergency room copayment
- $0 copayment for inpatient/outpatient surgery
- $7,150 Self Only / $14,300 Self Plus One / $14,300 Self and Family maximum out of pocket

Standard Option Overview

- $500 Self Only / $1,000 Self Plus One / $1,000 Self and Family Deductible
- 20% coinsurance after deductible up to $2,500 Self Only / $5,000 Self Plus One or Self and Family medical deductible and coinsurance limit
- $15 primary care provider office copayment ($0 for children under 18 years of age)
- $25 specialist office copayment ($0 for children under 18 years of age)
- $25 urgent care copayment
- $100 emergency room copayment
- $500 copayment per inpatient hospitalization (up to a maximum of 2 copayments per member per contract year)
- $250 copayment per outpatient surgery (up to a maximum of 2 copayments per member per contract year)
- $7,150 Self Only / $14,300 Self Plus One / $14,300 Self and Family maximum out of pocket

Section 5(a) Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appearin this section but are performed in an ambulatory surgical center or theoutpatient department of a hospital.
- The calendar year deductible for the Standard Option is: $500 per person (maximum of $1,000 per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to some benefits in this section. There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • Advance care planning	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing	Adult (18 and older): $15 per visit for primary care, chiropractic, optometry and behavioral health; $25 per visit for most specialty and urgent care. Children (under 18 years of age): Nothing
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
Out-of-area care • Medically necessary, non-urgent, non-emergent follow-up medical care	50% of our allowance with Prior Authorization	50% of our allowance with Prior Authorization
Not covered: Paternity testing, hair analysis (unless lead or arsenic poisoning is suspected), cytotoxic testing in conjunction with allergy testing.	*All charges.*	*All charges.*
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Electrocardiogram and EEG	Nothing	Nothing

Benefit Description	You Pay	
High-tech Radiology Testing	**High Option**	**Standard Option**
Tests such as: • MRI, MRA, CT/CAT, PET scans, • Ultrasound • Nuclear Medicin scans Note: High Tech Radiology Testing must be prior authorized by Physicians Plus Insurance Corporation.	Nothing	20% coinsurance after deductible
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every year.	Nothing	Nothing
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening , including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older.	Nothing	Nothing
Well woman care, including but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive years.	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: https://www.healthcare.gov/preventive-care-benefits/ CDC: http://www.cdc.gov/vaccines/schedules/index.html Women's preventive services: https://www.healthcare.gov/preventive-care-women/	Nothing	Nothing
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*	*All charges.*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22 • Examinations, such as: • Eye exams through age 17 to determine the need for vision correction, which include: • Hearing exams through age 17 to determine the need for hearing correction, which include: • Examinations done on the day of immunizations (ages 3 up to age 22) • Examinations for amblyopia and strabismus – limited to one screening examination (ages 3 through 5)	Nothing	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/ .		
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**High Option**	**Standard Option**
Breastfeeding support, supplies and counseling for each birth.	Nothing	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 9 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	Nothing	Nothing
Not covered: Surrogate mother services; services outside the service area; or any services with a non-participating provider.	*All charges.*	*All charges.*
Family Planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis.	Nothing	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$25 per office visit	$25 per office visit
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges.*	*All Charges.*

Benefit Description	You Pay	
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: Intracervical insemination (ICI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. Note: Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination). For women without male partners or exposure to sperm, infertility is the inability to conceive after six cycles of artificial insemination or intrauterine insemination performed by a qualified specialist using normal quality donor sperm. A diagnosis of infertility for women without male partners or exposure to sperm is not established until 6 cycles are completed. The cost of these six cycles (including donor sperm) is not covered by the plan. Examples of covered infertility services for men may include medically necessary hormone testing, semen analysis, sperm function testing, chromosomal analysis, medical imaging, surgical correction of genitourinary tract abnormalities, and sperm extraction. Note: Infertility Treatment means services, tests, supplies, devices, or drugs, which are intended to promote fertility; achieve pregnancy; or treat an illness causing an infertility condition when such treatment is done solely in an attempt to bring about a pregnancy. Note: Infertility services are covered if the couple has a relationship under which the FEHB Program recognizes each partner as a spouse of the other. FEHB does recognize same sex marriages.	50% coinsurance	50% coinsurance (Does not apply to deductible and coinsurance limit. However, it still applies toward the catastrophic maximum out-of-pocket.)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Intravaginal insemination (IVI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures*	*All Charges.*	*All Charges.*

Infertility services - continued on next page

Benefit Description	You Pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *Cost of donor sperm* • *Cost of donor egg.* • *Sperm enhancement services*	*All Charges.*	*All Charges.*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$25 per office visit	20% coinsurance after deductible
• Allergy injections • Allergy serum	Nothing	20% coinsurance after deductible
Not covered: Cytotoxic testing in conjuction with allergy testing; provocative food testing; and sublingual allergy desensitization.	*All charges.*	*All charges.*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • Growth hormone therapy (GHT) Note: Growth hormone therapy (GHT) is covered under the prescription drug benefit. See section 5(f).	Nothing	20% coinsurance after deductible
Physical and occupational therapies	**High Option**	**Standard Option**
Two consecutive months for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy to restore bodily function when a provider: • Orders the care Note: Phase II Cardiac rehabilitation will be covered for up to 36 sessions in an 18 consecutive week period for (a) myocardial infarction; (b) coronary bypass surgery; (c) onset of sable angina pectoris; (d) onset of decubital angina; (e) heart-valve surgery; (f) percltaneous tranluminal angioplasty; or (g) heart transplant. Note: Therapy must be prior authorized by Physicians Plus Insurance Corporation.	Nothing	$15 per office visit $15 per outpatient visit Nothing per visit during covered inpatient admission

Physical and occupational therapies - continued on next page

Benefit Description	You Pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
Note: Biofeedback for stress urinary and colorectal incontinence is limited to biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry.	Nothing	$15 per office visit $15 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • Dry Needling	*All Charges.*	*All Charges.*
Speech therapy	**High Option**	**Standard Option**
• Two consecutive months per condition Note: Therapy must be prior authorized by Physicians Plus Insurance Corporation.	Nothing	$15 per visit
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
Hearing exam	Nothing	Nothing
Hearing testing for children through age 17. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Nothing	Nothing
Hearing aid coverage (Children - Ages 0-18): One standard model hearing aid per ear, replaceable every 36 months. Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	20%	20%
Hearing aid coverage (Adults - Age 19+): Limited to one standard model hearing aid per ear replaceable every 36 months. Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	20%	20%
Not covered: *Hearing services that are not shown as covered*	All charges	All charges
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Eye exam	$15 per visit	$15 per visit
• Annual eye refractions	Nothing	Nothing
• Initial lens per surgical eye following cataract surgery (contact lens or framed lens) Note: See *Preventive care, children* for eye exams for children.	20%.	20%

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

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Laser photokeratotomy* • *Laser keratectomy* • *Refractive keratoplasty* • *Radial keratectomy* • *Keratotomy* • *Excimer laser photorefractive keratectomy*	*All Charges*	*All Charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$25 per office visit. Children (under 18 years of age): Nothing	$25 per office visit. Children (under 18 years of age): Nothing
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*	*All charges.*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy (limited to 2 per member per contract year). • Corrective orthopedic applicances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: All prosthetics require prior authorization.	20%	20%

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
Note: Purchases or rentals exceeding $750 require prior authorization. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20%	20%
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All Charges.*	*All Charges.*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps • Compression stocking; limited to 2 pair per calendar year Note: Call us at 800-545-5015 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Note: Purchases or rentals exceeding $750, CPAP machines, replacement items, continuous glucose monitoring transmitter systems, mechanical stretching devices for contracture or joint stiffness, traction for cervical and lumbar pain, and enternal delivery pumps require prior authorization.	20%	20% (Does not apply to deductible and coinsurance limit. However, it still applies toward catastrophic maximum out-of-pocket.)
Not covered:	*All Charges*	*All Charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Services, supplies and/or equipment not Medically Indicated;* • *Services, supplies and/or equipment purchased through a pharmacy or non-Participating Provider/ vendor;* • *Repairs and replacement of equipment and supplies unless Prior Authorized by the Plan;* • *Lost or stolen supplies and/or equipment;* • *Disposable and/or over-the-counter supplies and/or equipment including adult diapers (and related supplies), gauze bandages, incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings,surgical face masks and irrigating kits;* • *Routine periodic maintenance and/or battery replacements;* • *Medical Supplies and Durable Medical Equipment for comfort or personal hygiene and convenience, including air cleaners, air conditioners, humidifiers, physical fitness equipment, Physician's equipment, tanning beds, whirlpools, swimming pools, hot tubs, sauna's, alternative communication devices, Disposable Supplies, self help devices and equipment not medical in nature;* • *Eye glasses, lenses or frames and fittings, except as specifically listed in this brochure;* • *Home testing devices and monitoring supplies and related equipment except those used in connection with the treatment of diabetes;* • *Purchases or lease of, or modifications to, residences, places of work or motor vehicles;* • *Enteral feeding Disposable Supplies including bags, tubing, non-prescription or over-the-counter enteral feeds/supplements; nutritional supplements; or vitamins.*	*All Charges*	*All Charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: Home care must be prior authorized by Physicians Plus Insurance Corporation	Nothing	20% coinsurance after deductible
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All Charges.*	*All Charges.*

Home health services - continued on next page

Benefit Description	You Pay	
Home health services (cont.)	**High Option**	**Standard Option**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All Charges.*	*All Charges.*
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	Adult: $15 per office visit; Children (under 18 years of age): Nothing	Adult: $15 per office visit; Children (under 18 years of age): Nothing
Not covered: Long-term and/or maintenance therapy and service not medically indicated.	*All charges*	*All charges*
Autism Services	**High Option**	**Standard Option**
This policy will provide coverage for a primary verified diagnosis of Autism Spectrum Disorder. Autism Spectrum Disorder means: 1) Autism; 2) Asperger's syndrome; or 3) Pervasive developmental disorder not otherwise specified. Physicians Plus reserves the right to require a second opinion diagnosis with a participating provider. All intensive services require prior authorization.	Adult: $15 per office visit; Children (under 18 years of age): Nothing	Adult: $15 per office visit; Children (under 18 years of age): Nothing
Alternative treatments	**High Option**	**Standard Option**
Acupuncture (up to 12 visits per year if prior approved).	Adult: $15 per office visit; Children (under 18 years of age): Nothing	Adult: $15 per office visit; Children (under 18 years of age): Nothing
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback (except for stress urinary and colorectal incontinence)*	*All Charges.*	*All Charges.*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: Tobacco cessation programs, including individual/ group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Physicians Plus case management programs: • Diabetes self management • Asthma • Attention Defecit & Hyperactivity Disorder (ADHD) • Back Pain • Chronic Pain	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Depression • Heart Failure • High Blood Pressure • High Cholesterol • Insomnia • Migraines • Childhood Obesity Education Note: Please call Physicians Plus Insurance Corporation at (800) 545-5015 for details.	Nothing	Nothing

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

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

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services requireprecertification and identify which surgeries require precertification.

Benefit Description	You Pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Surgical treatment of morbid obesity (bariatric surgery) is covered with prior authorization from the Health Plan and when the following criteria is met: • The individual must be over 18 years of age; • The individual must have a documented BMI of 40 or greater, or a BMI of 35-39 with documented severe medical problems due to obesity, such as diabetes, hypertension, cardiac disease or a sleep disorder • The individual must have a confirmed history of failed nonsurgical weight loss treatment; • The individual has no current substance abuse or inadequately treated major psychiatric disorders; • The individual is a non-smoker; • Requires a three-month waiting period where the individual must adhere to the bariatric surgery program pre-surgical requirements which include attendance at a group educational seminar on obesity and bariatric surgery, a letter of referral/ endorsement from their PCP, attendance at a support group prior to surgery, a health psychological screening/assessment, approval from the program's interdisciplinary team, and attendance at a dietician education group session.	Nothing	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Foot care)*	*All Charges.*	*All Charges.*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts;	Nothing	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
- treatment of any physical complications, such as lymphedemas; - breast prostheses; and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All Charges.*	*All Charges.*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
ORAL SURGERY: Physicians Plus will cover only the services listed below. A participating oral surgeon must perform all services. Covered services include any x-rays and anesthesia related to the listed oral surgery services only: • Removal of third molars (wisdom teeth); • Removal of impacted teeth; • Incision or excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; • Surgical procedures to correct injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth; • Apicoectomy (excision of the apex of the tooth root); • Excision of exostosis (bony-outgrowth) of the jaws and hard palate for the purpose of constructing dentures; • External incision and drainage of cellulitis of the mouth; • Incision of accessory sinuses; incision or excision of salivary glands or ducts; • Residual root removal; • Alveolectomy (the leveling of structures supporting the teeth for the purpose of fitting dentures), if not performed in connection with the extraction of natural teeth; • Root amputation; • Treatment of fractures of facial bones; • Surgical exposure of teeth for orthodontic purposes (bonding and bracketing are excluded); • Intraoral incision, drainage or biopsies.	Nothing	20% coinsurance after deductible

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
Physicians Plus will cover diagnostic services and Medically Indicated surgical and non-surgical treatment (including intraoral splint therapy devices) for the correction of temporomandibular disorders (TMD) if all of the following apply: • A congenital, developmental or acquired deformity, disease or Injury caused the condition; and • The service or device is reasonable and appropriate for the diagnosis or treatment of this condition as determined by Physicians Plus; and • The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. Note: A Participating Provider designated to treat TMD must provide the services for all TMD services including intraoral splint therapy devices. The splint therapy device is considered Durable Medical Equipment.	Nothing	20% coinsurance after deductible
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges.*	*All Charges.*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas.	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
The **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	Nothing
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Pineoblastoma • Neuroblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic syndromes	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Neuroblastoma	Nothing	Nothing
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Beta Thalassemia Major • Chronic inflammatory demyelination polyneuropathy (CIDP) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Sickle Cell anemia Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MSDs) • Myelopysplasia/Myelodysplastic Syndromes • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia Autologous Transplants for • Advanced Childhood kidney cancers • Advanced Ewing sarcoma • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Aggressive non-Hodgkin's lymphomas • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Small cell lung cancer • Systemic lupus erythematosus • Systemic sclerosis	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
National Transplant Program (NTP) - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	Nothing	Nothing
Not covered: - *Donor screening tests and donor search expenses, except as shown above* - *Implants of artificial organs* - *Transplants not listed as covered*	*All Charges.*	*All Charges.*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible for the Standard Option is: $500 per person (maximum of $1,000 per Self Plus One enrollment or Self and Family enrollment). There is no deductible for the High Option.
- There is a $500 copayment per hospitalization (up to a maximum of 2 copayments per member per contract year) and a $250 copayment per outpatient surgery (up to a maximum of 2 copayments per member per contract year) for the Standard Option. There is no copayment for inpatient hospitalization and outpatient surgery for the High Option.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing	Nothing (covered in the inpatient admission copay)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	Nothing (covered in the inpatient admission copay)
Not covered: • *Custodial care*	*All Charges.*	*All Charges.*

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take home drugs* • *Respite care* • *Private duty nursing care* • *Coma therapy care; coma rehabilitation therapy*	*All Charges.*	*All Charges.*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Prior authorization is required.	Nothing	$250 copayment per stay (up to a maximum of 2 copayments per member per contract year)
Not covered: • *Blood and blood derivatives not replaced by the member* • *Reversal of sterilization* • *Cosmetic procedures*	*All Charges.*	*All Charges.*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Extended care benefit: this plan will cover skilled nursing care up to 100 days per confinement per member. The member must be admitted to a Physicians Plus-approved facility within 24 hours of discharge from a hospital for continued treatment of the same condition that required in-patient hospital care. Covered services include: • Semi-private (or lesser) room and board	Nothing	$500 copayment per stay (up to a maximum of 2 copayments per member per contract year)

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You Pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**	**Standard Option**
• Incremental nursing services • Miscellaneous hospital expenses • Intensive care room and board • Inpatient physical, speech and occupational therapy • Inpatient medications • Inpatient lab services and x-rays	Nothing	$500 copayment per stay (up to a maximum of 2 copayments per member per contract year)
Not Covered: • *Custodial care* • *Domiciliary care* • *Maintenance* • *Private duty nursing care* • *Respite care*	*All Charges.*	*All Charges.*
Hospice care	**High Option**	**Standard Option**
Physicians Plus will cover hospice care when: the member has a life expectancy of 6 months or less; care is provided by a participating licensed care provider.	Nothing	$500 copayment per stay (up to a maximum of 2 copayments per member per contract year)
Not covered: Independent nursing, homemaker services; private duty nursing.	*All Charges.*	*All Charges.*
End of life care	**High Option**	**Standard Option**
• Advanced care planning / palliative care consults	Nothing	Nothing
Ambulance	**High Option**	**Standard Option**
• Local professional ambulance service when medically appropriate	Nothing	20% coinsurance after deductible

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for the Standard Option is: $500 per person (maximum of $1,000 per Self Plus One enrollment or Self and Family enrollment). The calendar year deductible applies to some benefits in this section. There is no deductible for the High Option.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

WHAT IS A MEDICAL EMERGENCY?

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

WHAT TO DO IN CASE OF EMERGENCY:

Emergencies within our service area: If You require emergency medical care and you are in the Physicians Plus service area, you should go to a participating hospital emergency room for services when you can safely do so. If you cannot safely travel to a participating hospital and there is a closer non-participating hospital, you should go to that closer hospital emergency room for assistance and notify Physicians Plus within 48 hours or as soon as medically possible. If you are admitted to either a participating hospital or non-participating hospital, you and/or the hospital must notify Physicians Plus within 48 hours of the admission or as soon as medically possible.

Emergencies outside our service area: If you are out of the Physicians Plus Service Area and require emergency medical care and cannot safely return to the service area to receive that care, you should go to the closest hospital emergency room and notify Physicians Plus within 48 hours or as soon as medically possible. If you are admitted to the non-participating hospital, you and/or the hospital must notify us within 48 hours or as soon as medically possible.

Once you are stable, Physicians Plus will seek to have you transferred to a participating hospital in our service area. If you are not transferred to a participating hospital, Physicians Plus will coordinate your care with the hospital and physicians.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per Emergency Room visit	$100 per Emergency Room visit

Benefit Description	You pay	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per Emergency Room visit	$100 per Emergency Room visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ambulance service (ground or air) when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	20% coinsurance after deductible
Not covered: Ground or air ambulance when medical attention is not required en route to a medical facility.	*All Charges.*	*All Charges.*

Section 5(e) Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay	
Professional Services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Adult: $15 per office visit; Nothing (children under 18 years of age)	Adult: $15 per office visit; Nothing (children under 18 years of age)

Benefit Description	You Pay	
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing	Nothing
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility. • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services.	Nothing	$500 copayment per stay (up to maximum of 2 per member per year)
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility. • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment.	Nothing	Nothing
Not covered	**High Option**	**Standard Option**
Inpatient services that are not prior authorized and all out-of-network provider services.	All charges	All charges

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year deductible is: $0 per person ($0 per Self Plus One enrollment, or $0 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this section.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor. We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-545-5015.
- **These are the dispensing limitations.** Prescription drugs are dispensed and paid according to the drugs tier placement, as determined by the Physicians Plus Formulary. Your Plan may include a deductible, coinsurance, copayments and/or maximums.
  - Legend brand and generic drugs shall not exceed a 30-day supply or the smallest indivisible commercial package, whichever is great per copayment or coinsurance
  - Single packaged items are limited to no more than two of any kind or one-month supply, whichever is less, per copayment. A single packaged item includes, but is not limited to, inhalers, blood glucose testing strips, eye drops, and ear drops. Oral contraceptives are not considered single packaged items
  - Select preferred formulary medications are available for a three-month maintenance drug supply for three copays or your coinsurance at a community pharmacy or for two and a half (2.5) copays or your coinsurance at the mail order pharmacy. Select non-preferred formulary medications are available for a three-month supply at your coinsurance at either a community pharmacy or mail order pharmacy
  - Select medications are limited to a one-month supply and are required to be filled within the Physicians Plus specialty pharmacy network. Select specialty medications may also be part of the partial fill program. See the Premier Formulary document at www.pplusic.com for more information
  - Quantity limitations based on FDA dosage recommendations may be in place for some medications; and age and gender limitations may apply to some medication
  - Quantity limitations may be in place for some additional medications. Physicians Plus may initiate limitations. **Please check your Schedule of Benefits, call Physicians Plus Pharmacy Services or check the website formulary at www.pplusic.com for further information and additional quantity limits.**
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified. Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **Why use generic drugs?** Therapeutic equivalent generic substitution saves substantial amounts of money with the same clinical efficacy and safety as the brand product.
- **When you do have to file a claim.** Present your Physicians Plus member card to any pharmacy that accepts Argus prescription online claim processing. If you receive a prescription outside of the pharmacy network or a situation arises where the pharmacy cannot process the prescription under the Plan, you may submit a Direct Member Reimbursement Form with itemized receipt to Physicans Plus for covered prescription drugs. Please mail to: Physicians Plus Pharmacy Services, 2650 Novation Parkway, Madison, WI 53713 or FAX information to (608) 327-0324.

Benefits Description	You Pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan prescriber and obtained from a Plan pharmacy or through our mail order program for a 30-day supply: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles and syringes for the administration of covered medications. • FDA approved tobacco cessation products covered in full. • Drugs for sexual dysfunction Note: Some medications require prior authorization. Please visit our Web site at www.pplusic.com or contact Physicians Plus at (800) 545-5015 for medications and specialty medications requiring prior authorization. Specialty Medications: Contact Physicians Plus Insurance Corporation at (800) 545-5015 for the covered drug list or see the premier formulary located at www.pplusic.com. Note: All specialty medications require prior authorization and are required to be filled in the Physicians Plus specialty network. Partial fill program may be required for select medications. Note: Pharmacy specific $2,000 individual/$4,000 family out of pocket maximum. Note: If there is no generic equivalent available, you will have to pay the higher formulary tier copay/ coinsurance.	Tier 1 (Preferred Value Generics): $10 copay Tier 2 (Preferred Generics): $10 copay Tier 3 (Preferred Brands): 30% coinsurance (maximum of $75 per prescription) Tier 4 (Preferred Specialty Generics and Brands): 10% coinsurance (maximum of $200 per prescription) Tier 5 (Non-Preferred Generics, Brands and Specialty): 50% coinsurance (limited to 30-day supply) ACA preventive medication: Nothing	Tier 1 (Preferred Value Generics): $10 copay Tier 2 (Preferred Generics): $30 copay Tier 3 (Preferred Brands): 33% coinsurance (maximum of $200 per prescription) Tier 4 (Preferred Specialty Generics and Brands): 33% coinsurance (maximum of $200 per prescription) Tier 5 (Non-Preferred Generics, Brands and Specialty): 50% coinsurance (limited to 30-day supply) ACA preventive medication: Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: We only cover Growth Hormone Therapy (GHT) when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other Services* under *You need prior Plan approval for certain services* in Section 3. Note: Regardless of the tier your oral chemotherapy falls into you will never pay more than $100 for a 30-day supply, in compliance with the Wisconsin law.	Tier 1 (Preferred Value Generics): $10 copay Tier 2 (Preferred Generics): $10 copay Tier 3 (Preferred Brands): 30% coinsurance (maximum of $75 per prescription) Tier 4 (Preferred Specialty Generics and Brands): 10% coinsurance (maximum of $200 per prescription) Tier 5 (Non-Preferred Generics, Brands and Specialty): 50% coinsurance (limited to 30-day supply) ACA preventive medication: Nothing	Tier 1 (Preferred Value Generics): $10 copay Tier 2 (Preferred Generics): $30 copay Tier 3 (Preferred Brands): 33% coinsurance (maximum of $200 per prescription) Tier 4 (Preferred Specialty Generics and Brands): 33% coinsurance (maximum of $200 per prescription) Tier 5 (Non-Preferred Generics, Brands and Specialty): 50% coinsurance (limited to 30-day supply) ACA preventive medication: Nothing
Not covered: • *Drugs and supplies for cosmetic purposes, sexual dysfunction or for procedures/services that are not covered by the plan.* • *Anabolic steroids(except for replacement therapy and an approved prior authorization request), compounded hormone products, medications leading to or after a sex transformation surgery or drugs to modify stature except as approved by the plan.* • *Fertility drugs, tobacco cessation or over-the-counter drug items not approved by the plan.* • *Drugs obtained at non-Plan pharmacy; except for out of area emergencies. Lost, stolen or forgotten prescriptions are not covered.* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them.* • *Unitdose or injectable medications. Medications administered by a health care professional or institution (medical clinic, home nursing/rest/ respite care, nursing home, hospital, workers compensation, incarceration, military service or Medicare) are not covered by the plan.* • *Charges for a non-formulary or prior authorization medication not approved by the plan.* • *Nutritional supplements.*	*All Charges.*	*All Charges.*
Mail Order Prescription Drug Benefit • Up to 90-day supply	**Mail order - If member receives three-month supply:**	**Mail order - If member receives three-month supply:**

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Mail order available Tier 1, 2, 3, 5 and ACA preventive medications. Tier 4 not covered under mail order. Specialty medications are required to be filled in the Physicians Plus specialty network. Note: If there is no generic equivalent available, you will have to pay the higher formulary tier copay/ coinsurance.	**Mail order - If member receives three-month supply:** Tier 1 (Preferred Value Generics): $25 copay Tier 2 (Preferred Generics): $25 copay Tier 3 (Preferred Brands): 30% coinsurance (maximum of $187.50 per three month supply) Tier 4: Not Covered under mail order. Tier 5 (Non-Preferred Generics, Brands, and Specialty): 50% coinsurance	**Mail order - If member receives three-month supply:** Tier 1 (Preferred Value Generics): $25 copay Tier 2 (Preferred Generics): $75 copay Tier 3 (Preferred Brands): 33% coinsurance (maximum of $500 per three month supply) Tier 4: Not Covered under mail order. Tier 5 (Non-Preferred Generics, Brands, and Specialty): 50% coinsurance
Infertility Medications: Pharmacy Benefit oral infertility drugs Note: All infertility medications require prior authorization from Physicians Plus Insurance Corporation.	50% coinsurance	50% coinsurance
Select Formulary Over-the-Counter Medications (OTCs) Note: Select OTC medications are covered with a prescription order. Please visit www.pplusic.com or call (800) 545-5015 for a list of covered formulary OTC medications	Nothing	Nothing
Women's contraceptive drugs and devices Note: Over-the-counter contraceptives drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing	Nothing
Preventive care medications	**High Option**	**Standard Option**
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 6 months - 1 year		

Preventive care medications - continued on next page

Benefits Description	You Pay	
Preventive care medications (cont.)	**High Option**	**Standard Option**
• Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.		

Section 5(g) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing	20% coinsurance after deductible

Dental benefits

- We have no other dental benefits.

Section 5(h) Special features

Special feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 866-PPLUSRN (866-775-8776) and talk with a registered nurse who will discuss treatment options and answer your health questions.
Online Access	Physicians Plus MyChart provides Physicians Plus members with 24/7, self-service, online access to personal health plan information. With just a few clicks, members can: • Update personal information • Order new ID cards • Review benefit, copay, and other information • Review medical claims data and status • View charges to the health plan for services and procedures • View pharmacy claims and prescription costs Anyone who participates in a Physicians Plus health plan is eligible to register for online access to his or her own information. Visit our website at www.pplusic.com for more details.
MobileNurse	A free smartphone application that can direct you what to do and when (of if) you need to seek care when you or your family get sick. MobileNurse is available on the iTunes and Android app stores. Visit our Web site at www.pplusic.com for more details.
Federal Employee Wellness Program	Adults (employees and spouses) are eligible for a $75 limited Visa credit card for completing both our online personal health assessment and a biometric screening (includes blood pressure, glucose, cholesterol, and body mass index). The limited Visa credit card can only be used for qualified medical, dental, and prescription drug expenses.
Medicare Program for Annuitants	Physicians Plus waives all medical copays, coinsurance, and deductibles for annuitants with both Medicare parts A & B, whether on the High Option or Standard Option.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact Physicians Plus Insurance Corporation at (800) 545-5015 or visit our website at www.pplusic.com.

WellPlus Portal. It's your digital connection to health and wellness! Visit our website at www.pplusic.com and create your account to access:

- Personal Health Assessment - Connect to health information that is unique to you based on your health history, health practices and personal goals.
- Health Resources - Use the WellPlus tracking tools, wellness workshops, health content, exercise, and meal plans and food tracking to help you live better.

Rx Manager allows personal review of prescription drug history, the Physicians Plus drug formulary and drug cost comparisons. It's especially useful for helping you choose lower-cost drugs or those with lower copays.

PerkSpot discounts. PerkSpot is a one-stop shop for exclusive discounts at some of your favorite national and local merchants.

NursePlus (866-PPLUSRN/866-775-8776) provides support from a registered nurse any time day or night, to answer your health care questions and help you live healthier. NursePlus can help you:

- Choose the most appropriate course of care for any medical condition.
- Understand your doctor's or pharmacist's instructions or discuss medication side effects.
- Support your relationship with your doctor and prepare for doctor visits.
- Access a comprehensive audio library of over 700 clinically based topics.

MobileNurse. A free smartphone application that can direct you what to do and when (of if) you need to seek care when you or your family get sick. MobileNurse is available on the iTunes and Android app stores. Visit our website at www.pplusic.com for more details.

Individual Health Insurance. If you or a family member are not eligible under the FEHB Plan benefits, Physicians Plus offers a variety of individual and family health insurance plans. For more information, contact Physicians Plus at (608) 282-8900 or visit our website at www.pplusic.com.

Section 6 General exclusions – services, drugs and supplies we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. F**or information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies you receive without charge while in active military service

Section 7 Filing a claim for covered services

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

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 800-545-5015.

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

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your claims to:

Physicians Plus Insurance Corporation, Attn: Claims Department, 2650 Novations Parkway, Madison, WI 53713

Prescription drugs

Submit your claims to:

Physicians Plus Insurance Corporation, Attention: Pharmacy Services, 2650 Novations Parkway, Madison, WI 53713

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

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

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

Section 8 The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.pplusic.com.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Member Service Department by writing Physicians Plus, 2650 Novation Parkway, Madison, WI 53713 or calling (800) 545-5015.

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

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

The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

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

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: Physicians Plus Insurance Corporation, Attn: Grievance Administrator, 2650 Novation Parkway, Madison, WI 53713; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

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

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information.

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

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

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

3

You must write to OPM within:

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

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

Send OPM the following information:

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

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

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

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

4

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-545-5015. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p. m. Eastern Time.

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

Section 9 Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

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

- **TRICARE and CHAMPRA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare:

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age

- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-877-486-2048) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-545-5015 or see our website at www.pplusic.com.

We waive medical copays, coinsurance and deductibles if you are a Medicare annuitant (retiree) and have both Medicare Parts A & B (the Original Medicare is your primary payor for Medicare Parts A & B costs.)

Please review the following table which illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	High Option: $0 Standard Option: $500	$0
Out of Pocket Maximum	Self Only: $7,150 Self Plus One: $14,300 Self and Family: $14,300	Self Only: $7,150 Self Plus One: $14,300 Self and Family: $14,300
Primary Care Physician	$15	$0
Specialist	$25	$0
Inpatient Hospital	High Option: $0 Standard Option: $500 copayment	$0
Outpatient Hospital	High Option: $0 Standard Option: $250 copayment	$0

You can find more information about how our plan coordinates benefits with Medicare at www.pplusic.com.

Tell us about your Medicare coverage

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan:

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

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

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

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

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

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

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

Section 10 Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered Services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care or Maintenance care means care which can be learned and performed by a person who is not medically trained or care which involves the maintenance of basic bodily functions whether by natural or artificial means; care which includes care required for patient safety; and care which includes Respite Care, which is care that is requested to give temporary relief to persons who normally assist with the care of the Member.

Experimental or investigational service

Experimental/Investigative means drugs, devices, treatment, or procedures, which in judgment of a Physicians Plus medical director, meet one of the following criteria:

(A) Full and final approval has not been granted by the U.S. Food and Drug Administration for the treatment of the patient's medical condition;

(B) Specific evidence shows that the drug, device, treatment, or procedure is being provided subject to: a phase I or phase II clinical trial or the Experimental arm of a phase III clinical trial; a protocol to determine the safety, toxicity, maximum tolerated dose, efficacy, or efficacy in comparison to the standard means of treatment or diagnosis; or a protocol approved by and under the supervision of an Institutional Review Board;

(C) The published authoritative medical and scientific literature: has not defined or supports further research to define the safety, toxicity, maximum tolerated dose, efficacy or efficacy in comparison to the standard means of treatment or diagnosis; or does not demonstrate clinically significant improvement in the efficacy or outcomes for the drug, device, treatment or procedure compared to standard drugs, devices, treatments, or procedures.

Health care professional

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

Medical necessity

Medically Indicated or Medically Necessary means a service, treatment, procedure, equipment, drug, device or supply provided by a Hospital, Physician or other health care Provider that is required to identify or treat a Member's Illness or Injury and which is, as determined by Physicians Plus:

(A) Consistent with the symptom(s) or diagnosis and treatment of the Member's lllness or Injury;

(B) Appropriate under the standards of acceptable medical practice to treat that Illness or Injury;

(C) Not solely for the convenience of a Member, Physician, Hospital or other health care Provider;

(D) The most appropriate service, treatment, procedure, equipment, drug, device or supply that can be safely provided to the Member in the most cost effective manner; and

(E) Not deemed Experimental or Investigational in nature. The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular Injury or Illness does not necessarily mean it is Medically Indicated.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: **Usual and Customary** means the Usual and Customary amount payable based upon the average Charge for the same service provided by other Providers of a similar type, training, and experience, in the same or similar geographical area and should not exceed the fees that the Provider would Charge any other payor for the same services. Other factors such as, but not limited to, complexity, degree of skill or type of Provider may also determine a Usual and

Customary fee. Amounts above the Usual and Customary amounts are not paid by this Policy and are not applied to Policy and/or benefit maximums and/or Deductible amounts, Copaymentments and Coinsurance.

Post-service claims

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

Pre-service claims

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

Reimbursement

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

Subrogation

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

Urgent care claims

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Member Service department at (800) 545-5015. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to Physicians Plus Insurance Corporation.

You You refers to the enrollee and each covered family member.

Section 11 Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose Self Only, Self Plus One, or Self and Family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 866-353-8058.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557), or visit www.ltcfeds.com .

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Summary of benefits for the High Option of Physicians Plus Insurance Corporation - 2017

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing	25
Services provided by a hospital:		
• **Inpatient**	Nothing	46
• **Outpatient**	Nothing	47
Emergency benefits:		
• **In-area**	$100 per emergency room visit	49
• **Out-of-area**	$100 per emergency room visit	50
Mental health and substance abuse treatment:	Adult: $15 copay per visit; Child (Age 0-17): Nothing	51
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	• Tier 1 Generics (Preferred Value Generics): $10 copay. • Tier 2 (Preferred Genetics): $10 copay. • Tier 3 (Preferred Brands): 30% coinsurance (maximum of $75 per prescription). • Tier 4 (Preferred Specialty Generics & Brands): 10% coinsurance (maximum $200 per prescription). • Tier 5 (Non-Preferred Generics, Brands & Specialty): 50% Coinsurance	53
• Mail order (up to a 90-day supply)	• Tier 1: $25 copay (90-day supply). • Tier 2: $25 copay (90-day supply). • Tier 3: 30% coinsurance (maximum of $187.50 for 90-day supply). • Tier 4: Not eligible for mail order. • Tier 5: 50% Coinsurance	54

High Option Benefits	You pay	Page
Dental care:	No benefit (except for accidental injury).	58
Vision care:	$15 office visit copay	31
Protection against catastrophic costs:		
• **Deductible**	None	24
• **Coinsurance**	None	24
• **Maximum Out-of-Pocket (Includes Medical and Pharmacy Copays, Coinsurance and Deductible)**	$7,150 Self Only / $14,300 Self Plus One or Self and Family	24

Summary of benefits for the Standard Option of Physicians Plus Insurance Corporation 2017

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
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- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Adult (18 and older): $15 per office visit for primary care, chiropractic, optometry and behavioral health; $25 per office visit for most specialty and urgent care. Children (under 18 years of age): Nothing	25
Services provided by a hospital:		
• Inpatient	$500 copayment (up to 2 per year)	46
• Outpatient	$250 copayment (up to 2 per year)	47
Emergency Benefits:		
• In-area	$100 per emergency room visit	49
• Out-of-area	$100 per emergency room visit	50
Mental health and substance abuse treatment:	Adult: $15 copay per visit; Child (Age 0-17): Nothing	51
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	• Tier 1 Generics (Preferred Value Generics): $10 copay. • Tier 2 (Preferred Genetics): $30 copay. • Tier 3 (Preferred Brands): 33% coinsurance (maximum of $200 per prescription). • Tier 4 (Preferred Specialty Generics & Brands): 33% coinsurance (maximum of $200 per prescription). • Tier 5 (Non-Preferred Generics, Brands & Specialty): 50% Coinsurance	53
• Mail order (up to a 90-day supply)	• Tier 1: $25 copay (90-day supply). • Tier 2: $75 copay (90-day supply). • Tier 3: 33% coinsurance (maximum of $500 for 90-day supply). • Tier 4: Not eligible for mail order. • Tier 5: 50% Coinsurance	54

Standard Option Benefits	You Pay	Page
Dental care:	No benefit (except for accidental injury).	58
Vision Care:	$15 office visit copay	31
Protection against catastrophic costs:		
• Deductible	$500 Self Only / $1,000 Self Plus One or Self and Family.	24
• Coinsurance	20% Coinsurance	24
• Deductible and Coinsurance Limit	$2,500 Self Only / $5,000 Self Plus One or Self and Family (excludes copays, DME, and infertility coinsurance). However, they still count toward catastrophic maximum out-of-pocket.	24
• Maximum Out-of-Pocket (Includes Medical and Pharmacy Copays, Coinsurance and Deductible)	$7,150 Self Only / $14,300 Self Plus One or Self and Family	24

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

For 2017 health premium information, please see: https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribe's Human Resources department.