Physicians Health Plan of Northern Indiana

http://www.phpni.com

Customer service 1-800-982-6257

2015

A Health Maintenance Organization with a high plan option and a high deductible health plan option

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 15
- Summary of benefits: Page 123

Serving: Northeast Indiana

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment codes for this Plan:

DQ1 Self Only

DQ2 Self and Family

DQ4 High Deductible Health Plan (HDHP) Self Only

DQ5 High Deductible Health Plan (HDHP) Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-583

Important Notice from Physicians Health Plan of Northern Indiana

About Our Prescription Drug Coverage and Medicare

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

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Physicians Health Plan of Northern Indiana 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).

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Introduction

This brochure describes the benefits of Physicians Health Plan of Northern Indiana, Inc., under our contract (CS 2648) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1/800-982-6257 or through our website: www.phpni.com. The address for Physicians Health Plan of Northern Indiana, Inc.'s administrative office is:

Physicians Health Plan of Northern Indiana, Inc.

8101 West Jefferson Boulevard

Fort Wayne, Indiana 46804-4163

This brochure is the official statement of benefits. No oral 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 and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 15. 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 Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) statements 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 (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired; or contact us through our website at www.phpni.com 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/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- 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.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 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 your pharmacist about the medication 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.

3.Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital 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.

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 reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. 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 hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

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, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  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/healthcare-insurance for enrollment information as well as:

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

  Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

  Self Only coverage is for you alone. Self 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 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 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 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.

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, 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.

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

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self 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 and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family 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. 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 2015 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 2014 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).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **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, regardless of marital status, 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, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. 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 FEHBP coverage.

- **Finding replacement coverage**

This Plan no longer offers its own non-FEHB plan for conversion purposes. 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.

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 1/800/982-6257 or visit our website at www.phpni.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 Plan physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their 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.

Physicians Health Plan of Northern Indiana does not require you to choose one primary care doctor. What makes Physicians Health Plan of Northern Indiana special is that as a Plan member you will have the freedom to receive your medical care from any of the more than 1,454 private practice doctors in all specialties at more than 3,775 locations. In addition, there are over 61,325 neighborhood participating pharmacies, 63 participating hospitals and over 48 urgent care and surgery facilities.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, deductibles and/or coinsurance 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 Plan

We have Open Access benefits

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

How we pay providers

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

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

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.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA or Indian Health Services (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

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 $5,000 for Self Only enrollment, or $10,000 Self and Family coverage.

Your rights

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

- We are licensed by the State of Indiana and in compliance with all applicable state laws and regulations.
- We were founded by a group of local doctors in 1983.
- We are a not-for-profit managed care insurance company.

For an expanded version of our Member Rights and Responsibilities Statement, please visit our website at www.phpni.com. If you want more information about us, call (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired, or write to Physicians Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804-4163. You may also contact us by fax at (260) 432-0493 or visit our website at www.phpni.com.

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 where you will find Plan providers and facilities. Our service area includes the following Indiana counties: Adams, Allen, DeKalb, Elkhart, Fulton, Jay, Huntington, Kosciusko, LaGrange, LaPorte, Marshall, Miami, Noble, Pulaski, St. Joesph, Starke, Steuben, Wabash, Wells, and Whitley.

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 2015

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

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only and Self and Family. See the 2015 Rate Information page.
- The medical deductible will increase to $500 for Self Only and $1,000 for Self and Family.
- The medical out-of-pocket limit will increase to $4,000 for Self Only and $8,000 for Self and Family.
- Hospital Emergency (ER) copayment will increase to $300.
- Office visit copays will increase to $20 for primary care and $40 for specialist visit.
- 30 day retail prescription drug copays have changed to $10 generic/$30 brand name formulary/$60 brand name non-formulary.
- 90 day retail prescription drugs are available now as follows: $30 generic/$90 brand name formulary/$180 brand name non-formulary.
- Mail order prescription drug copays have changed to $20 generic/$75 brand name formulary/$180 brand name non-formulary.
- The copay for Cancer Chemotherapy treatment has increased to a $30 copay.
- Home Health Services are limited to 90 days per calendar year.
- Custom molded foot orthotics are no longer limited to $500. These are covered at 20% coinsurance after the deductible and the out-of-pocket limit applies.
- Treatment for services of Temporomandibular joint dysfunction (TMJ) are limited to one treatment per side of head per lifetime. Services are covered at 20% coinsurance after the deductible and the out-of-pocket limit applies.

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 (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired or write to us at 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804. You may also request replacement cards through our website: www.phpni.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. Please remember you may be required to pay this amount when you receive services. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services rendered outside the service area unless there is a Plan authorization made in advance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

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

What you must do to get covered care

PHP is an "open access" Health Maintenance Organization. We do not require you to choose one primary care doctor and a referral is not necessary to see a participating specialist. You have the freedom to receive medical care from any of our Plan providers or facilities.

- **Primary care**

We recommend that you choose a Primary Care Physician to oversee your health care for the best overall quality of care. The person you select may specialize in Family and General Practice, Internal Medicine, Pediatrics, or Obstetrics/Gynecology.

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**

A wide range of specialists are available among the Plan's more than 2,499 participating doctors. You do not need a referral from a primary care doctor to see a specialist under the Plan. Consult the Plan Provider Directory or call the Customer Service Department at (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired, for a specialist near you.

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

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. 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.

We may approve referrals to non-Plan providers for covered health services when your physician recommends such care and it is not available from Plan providers. You must obtain all other related health services from Plan providers, including prescription drugs.

- **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 (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired. 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.*

- **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:

  - Durable Medical Equipment
    - AED Garments
    - Bi-Pap Machines
    - Breast Pumps
    - Chest Percussion Vests
    - C-Pap Machines
    - CPM Machines
    - Custom Made Oral Sleep Apnea Appliances
    - Enteral Feedings
    - Hospital Beds
    - Insulin Pumps
    - Lift Chairs
    - Oxygen Systems
    - Pain Pumps (I-Flow, etc.)
    - Pneumatic Lymphadema Treatment Devices
    - Prosthetics
    - Pressure Relief Devices
    - Standing Frames
    - Stimulators - Bone Growth, Muscle, Neuro, Sacral, Pain
    - UV Lights
    - Ventilators
    - Wheelchairs
  - Inpatient Services
    - All Inpatient Admissions (incuding Rehab, Behavioral Health, Hospice, Skilled Nursing Facility, Transitional Care Unit)
    - High Risk OB (please notify PHP by the 2nd trimester)
    - Multiple Births
  - Outpatient Services
    - Behavioral Health Testing
    - Home Health Services
    - Hospice
    - Inches Away Program
    - IOP Partial Behavioral Health
    - Out-of-Network Referrals
    - Sleep Studies
    - Transplantation Services
  - Procedures

- Bariatric Treatment
- Capsule Endoscopy
- Cochlear Implants
- Cyber Knife
- Cartilaginous Defect Procedures - ACI (Autologous Chondrocyte Implantation), Mosaic plasty, OATS (Osteochondral Autograft)
- Genetic Testing
- Obstructive Sleep Apnea Treatment including surgical procedures
- Oral Surgery - biopsies or treatment of oral lesions by oral surgeons, Orthognathic Surgery
- Radiology - MRI, MRA, CT, PET, Nuclear Medicine, Nuclear Cardiology, 3D Rendering
- Sclerotherapy
- Spine Surgeries - Artificial Disc, Dorsal Column Stimulators, Spinal Fusions
- Total Hips and Knees

• Reconstructive Procedures
  - Abdominoplasty
  - Blepharoplasty/Brow Suspension
  - Breast Reconstruction
  - Mandibular/Maxillary Reconstruction due to trauma or congenital anomalies
  - Nasal Fracture Repair
  - Reduction Mammoplasty
  - Rhinoplasty
  - Scar Revisions or other reconstructive procedures

Medications that cost $1,500 or more per prescription require prior authorization. Additional drugs requiring prior authorization include but are not limited to:

- Arcalyst
- Arzerra
- Boniva
- Botox
- Clotting Factor
- Fabrzyme
- IVIG (Intravenous Immune Globulin)
- Neulasta
- Prolia
- Reclast
- Synagis
- Xgeva
- Yervoy

Additional specialty pharmacy medications requiring prior authorization can be found in Section 5(f). Prescription drug benefits - Specialty pharmacy medications.

The above list is subject to periodic review and modification.

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 (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired, 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 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 provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of 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 (260) 432-6690, extension 11; (800) 987-6257, extension 11; or (260) 459-2600 for the hearing impaired. 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 (260) 432-6690, extension 11; (800) 987-6257, extension 11; or (260) 459-2600 for the hearing impaired. 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**

We will cover maternity services as we cover similar health services for any other sickness. Maternity services must be ordered by, provided by or under the direction of a doctor.

Inpatient, surgical, medical and professional coverage for a hospital stay is provided for a minimum of:

A. 48 hours for vaginal delivery; or

B. 96 hours for cesarean birth.

An authorization is required for a hospital stay in excess of 48 hours or 96 hours.

- **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.

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

If no authorization is received or approved, you will be responsible for all costs of such services.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

If 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 cost 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.

Copayments

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

Example: Under the High Option plan, when you see your primary care physician, you pay a copayment of $20 per office visit. When you see a specialist, you pay a copayment of $40 per office visit.

Deductible

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

- High Option Plan - The calendar year deductible for medical services is $500 per Self. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $1,000.
- High Deductible Health Plan - The calendar year deductible for Self is $2,000 and for Self and Family is $4,000.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 20% of the charges for laboratory services and 20% of hospital charges up to your catastrophic protection out-of-pocket maximum after you meet your deductible.

Your catastrophic protection out-of-pocket maximum

- High Option Plan: After your (copayments and coinsurance) totals $4,000 per Self or $8,000 per Self and Family enrollment in any calendar year, you do not have to pay coinsurance for certain covered medical services. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
- High Deductible Health Plan: After your deductible and coinsurance totals $5,000 per Self or $10,000 per Self and Family enrollment in any calendar year, your eligible medical expenses will be covered at 100%.

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.

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 reponsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High Option Benefits

See page 15 for how our benefits changed this year and page 123 for a benefits summary. This benefits section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. 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 our benefits, contact us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired, or on our website at www.phpni.com.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $500 per Self or $1,000 per Self and Family and applies to services when you pay a percentage of charges. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
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**
Professional services of physicians as follows: • Office medical consultations • Second surgical opinion	$20 per primary care visit $40 per specialist visit (No deductible)
Professional services of physicians • In an urgent care center	$40 per visit (No deductible)
Professional services of physicans • During a hospital stay • In an extended care or skilled nursing facility • Outpatient diagnostic or surgical care	20% of charges
At home	$20 per primary care visit $40 per specialist visit (No deductible)
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons* • *Professional services that are subject to exclusion*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% of charges
Preventive care, adult	**High Option**
Routine screenings, such as: • Routine Annual Physical • Total Blood Cholesterol • Colorectal Cancer Screening, including: - Fecal occult test (one test every year for adults ages 50 to 75) - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening (one screening every ten years starting at age 50 to 75) • Routine Prostate Specific Antigen (PSA) test • Routine Urinalysis Note: Maximum benefit payable for routine screenings listed above is one each per person per calendar year that we pay in full unless otherwise noted.	Nothing (No deductible)
Well woman care, including but not limited to: • Routine Pap test (one test every three years for women ages 21 to 65) • Routine mammogram (one test per year) • 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 (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) in the doctor's office.	Nothing (No deductible)
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/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	**High Option**
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons*	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child visits for routine examinations and care (up to age 22)	Nothing (No deductible)
• Eye exams for children through age 17 to determine the need for vision correction	$40 per specialist visit (No deductible)
• Hearing exams for children through age 17 to determine the need for hearing correction	$20 per primary care visit $40 per specialist visit (No deductible)
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/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons* • *Eyeglasses, contacts, or related supplies* • *Eye exercises*	*All charges*
Maternity care	**High 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	$20 per primary care visit for initial office visit only; 20% of charges thereafter or Nothing for services considered Preventive under the Affordable Care Act
Breastfeeding support, supplies and counseling for each birth	Nothing (No deductible)
Note: Here are some things to keep in mind: • 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.	

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
• 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. Circumcision is covered as a surgical procedure. See Section 5(b). *Surgical benefits.* • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
• Labs, sonograms, fetal stress tests, etc., not included in the global fee	20% of charges
Specialized obstetrical services such as: • Aminocentesis • Corionic Villi Sampling	$40 per specialist visit when performed in the doctor's office; otherwise, 20% of charges
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing (No deductible)
A range of voluntary family planning services, limited to: • Voluntary sterilization (See *Surgical procedures* Section 5(b).) • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$20 per primary care visit $40 per specialist visit (No deductible)
Surgically implanted contraceptive such as Norplant Note: Norplant is considered a commonly used "surgically" implanted device. Maximum benefit payable for Norplant is one implant per person every five calendar years.	$20 per primary care visit $40 per specialist visit (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	20% of charges

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
Note: We cover up to a 14-day supply of infertility medicines unless limited by drug manufacturer's packaging, per prescription or refill under the *Prescription drug benefit* (See Section 5(f).). Maximum benefit payable for Infertility drugs is $1,500 per person per calendar year. The calendar year maximum applies to all infertility drugs including those medications purchased at a pharmacy or injected in your physician's office.	20% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**High Option**
Testing	20% of charges
Treatment	$20 per primary care visit $40 per specialist visit (No deductible)
Allergy injection Allergy serum	Nothing if you receive these services during your office visit; otherwise, $20 per primary care visit or $40 per specialist visit (No deductible)
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**High Option**
Cancer Chemotherapy Treatment We will cover cancer chemotherapy treatment when ordered by and provided by a Plan Provider.	$30 copay (No deductible)
• Chemotherapy and radiation therapy • Dialysis - hemodialysis and peritoneal dialysis • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under *Organ/ Tissue Transplants*. Note: Respiratory and Inhalation therapy, home intravenous (IV) therapy, and antibiotic therapy are covered as *Home health services*.	20% of charges

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**High Option**
Note: We cover growth hormone therapy (GHT) under the *Prescription drug benefits*. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on page 18.	20% of charges
Not covered: Experimental, investigational or unproven services, treatments, supplies, drugs, devices, and procedures	*All charges*
Inpatient/Outpatient Short Term Rehab/Habilitation Services	**High Option**
• 20 visits per calendar year: - Physical therapy - Occupational therapy - Speech therapy - Pulmonary rehabilitation • 36 visits per calendar year: - Cardiac rehabilitation • 12 visits per calendar year: - Manipulation therapy Coverage is not provided for Therapy Services (Habilitation Services) treating chronic conditions for which there is no reasonable expectation of significant improvement. As explained in more detail below, We will Cover certain Therapy Services (Habilitation Services) that: A. are ordered by a Par Doctor; B. are provided by a Par Provider or Par Facility; C. will result, in the judgment of a Par Doctor and PHP, in a significant improvement of Your condition within two months after the start of such services; and D. are Medically Necessary. Coverage provided under this benefit is limited to the following: **Physical Medicine Therapy Services**	20% of charges

Inpatient/Outpatient Short Term Rehab/Habilitation Services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Inpatient/Outpatient Short Term Rehab/Habilitation Services (cont.)	**High Option**
A. **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. B. **Speech therapy** for the correction of a speech impairment. C. **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment. D. **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered. Experimental, Investigational and Unproven Services, such as but not limited to: VAXD; Lordex; ART; DRS; and posture pump are not Covered. **Other Therapy Services**	20% of charges

Inpatient/Outpatient Short Term Rehab/Habilitation Services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Inpatient/Outpatient Short Term Rehab/Habilitation Services (cont.)	**High Option**
A. **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered. Such cardiac rehabilitation must meet Our guidelines to be Covered. B. **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.	20% of charges
Not covered: • *Long-term rehab therapy* • *Exercise programs* • *Developmental therapies*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
• Hearing exam • Hearing testing for children, see Preventive care, children	$20 per primary care visit $40 per specialist visit (No deductible)
Not covered: Hearing aids and supplies	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing (No deductible)
• One routine eye exam for members age 18 and older every twelve months • Unlimited eye exams for children through age 17	$40 per specialist visit (No deductible)
Not covered: • *Eyeglasses, contact lenses, or related supplies, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Replacements for lenses during the same calendar year the lenses were provided due to accidental ocular injury or intraocular surgery (such as cataracts)*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$20 per primary care visit $40 per specialist visit (No deductible)
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*
Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies	**High Option**
• Artificial eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacement, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c). for payment information. See 5(b). for coverage of the surgery to insert the device Rental up to purchase price, or purchase at our option, of durable medical equipment prescribed by your Plan doctor. Under this benefit, we also cover: • oxygen • dialysis equipment • hospital beds • wheelchairs • crutches • walkers • audible prescription reading devices • blood glucose monitors • insulin pumps • orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, if we approve them in advance • ostomy supplies	20% of charges

Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies (cont.)	**High Option**
Note: Call us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired as soon as your Plan doctor 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 services when you call. Note: A separate maximum applies to Durable Medical Equipment to treat sexual dysfunction. Note: Ostomy Supplies are covered when used for the care of an artificial stoma or opening into the urinary, gastrointestinal canal and/or the trachea. 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% of charges
• Prosthetic arm, hand, leg or foot. Includes the orthotic device that is part of the prosthesis.	20% of charges
• Custom molded foot orthotics to be placed in shoes if ordered and/or provided by a Plan doctor Note: Orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, under *Durable medical equipment*, if we approve them in advance. (See Section 5(a).)	20% of charges
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) dysfunction Note: This benefit service is in combination with other TMJ services. See *Oral and maxillofacial surgery*.	20% of charges
Durable Medical Equipment to treat sexual dysfunction such as but not limited to: • penile implants • vacuum pumps Note: Maximum benefit payable for covered sexual dysfunction durable medical equipment is $1,000 per person per calendar year. Separate maximums apply to general durable medical equipment and ostomy supplies. Note: We cover certain drugs to treat sexual dysfunction under the Prescription drug benefits. See Section 5(f). Covered prescription drugs are subject to a separate $1,000 benefit maximum.	20% of charges
Not covered: • *Orthopedic and corrective shoes* • *Foot orthotics*	*All charges*

Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies (cont.)	**High Option**
• *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair or replacement of any non-medically necessary prosthetic devices* • *Motorized wheelchairs, scooters, lifts for wheelchairs; or motor vehicles* • *Repair or replacement of any non-medically necessary DME* • *Batteries to operate DME* • *Common household articles such as: air conditioners, humidifiers, and air purifiers* • *Disposable or non-durable medical supplies such as: elastic bandages, elastic support, and gauze*	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan doctor and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide • Services include oxygen therapy, intravenous therapy, antibiotic therapy, and medications if provided by a Plan home health care agency Note: 90 days per calendar year limit. Services such as physical and occupational therapy or durable medical equipment are subject to copayments or coinsurance. See also *Physical and occupational therapies*, *Speech therapy*, and *Durable medical equipment (DME).*	20% of charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Alternative treatments	**High Option**
• No benefit	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco Cessation program, including two (2) quit attempts per year with up to four (4) smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling and individual counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for four (4) counseling sessions for up to two (2) quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Coverage is limited to diabetes self-management training, meeting these minimum requirements: • One visit after receiving a diagnosis of diabetes • One visit after receiving a diagnosis that: - represents a significant change in the patient's symptoms or condition; and - makes a change in self-management necessary. • One visit for refresher or re-education training	$20 per primary care visit or $40 per specialist visit when performed in the doctor's office; otherwise 20% of charges

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is $500 per Self or $1,000 per Self and Family and applies to services when you pay a percentage of charges. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- The services listed below are for the charges billed by a Plan 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 pre-certification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**High 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*) • Circumcision (see *Maternity care*) • Surgical treatment of morbid obesity - a medical condition in which an individual has a body mass index (BMI) of at least 35 with co-morbidities, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes mellitus or a BMI of 40 without co-morbidities. See note below. • Insertion of internal prosthetic devices. See 5(a). - *Orthopedic and prosthetic devices* for device coverage information such as: artificial knuckles and joints, pacemakers, insulin pump, defibrillator. See note below. • Voluntary sterilization (e.g. Tubal ligation, Vasectomy) • Treatment of burns	$20 per primary care visit or $40 per specialist visit for surgery performed in the doctor's office; otherwise 20% of charges Note: All surgeries cannot be performed in the doctor's office; some must be performed in an outpatient facility such as a hospital or ambulatory surgery center.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
Note: We cover non-experimental, surgical treatment of morbid obesity that has persisted for at least five (5) years and you have received non-surgical treatment supervised by a doctor for at least 18 consecutive months that has been unsuccessful. 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.	$20 per primary care visit or $40 per specialist visit for surgery performed in the doctor's office; otherwise 20% of charges Note: All surgeries cannot be performed in the doctor's office; some must be performed in an outpatient facility such as a hospital or ambulatory surgery center.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot. (See Foot care)*	*All charges*
Reconstructive surgery	**High 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, webbed fingers, and webbed toes.	$20 per primary care visit or $40 per specialist visit for surgery performed in the doctor's office; otherwise 20% of charges Note: All surgeries cannot be performed in the doctor's office; some must be performed in an outpatient facility such as a hospital or ambulatory surgery center.
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - 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.	$20 per primary care visit or $40 per specialist visit for surgery performed in the doctor's office; otherwise 20% of charges Note: All surgeries cannot be performed in the doctor's office; some must be performed in an outpatient facility such as a hospital or ambulatory surgery center.
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* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$20 per primary care visit or $40 per specialist visit for surgery performed in the doctor's office; otherwise 20% of charges Note: All surgeries cannot be performed in the doctor's office; some must be performed in an outpatient facility such as a hospital or ambulatory surgery center.
• Treatment for services of Temporomandibular joint dysfunction (TMJ) Note: Limited to one treatment per side of head per lifetime. This benefit service is in combination with all TMJ services.	20% of charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Treatment of overbite or underbite, maxillary and mandibular osteotomies, dental x-rays, dental supplies, and appliances and all associated expenses* • *Orthodontic treatment or braces for teeth*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • 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	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • 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 - 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	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Sickle cell 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 - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure
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 - 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	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Neuroblastoma	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure
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 - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - 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 - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Multiple sclerosis - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous Transplants for - Advanced Ewing sarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Epithelial Ovarian Cancer - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasm)	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Mantle Cell (Non-Hodgkin's lymphoma)	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure
We use National Transplant Programs (NTP) - United Resource Networks (URN) and Interlink. Transplant services must be provided and arranged by a Plan doctor and performed at a designated transplant facility.	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure
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.	$20 per primary care visit or $40 per specialist visit; 20% of charges for transplant procedure
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not specifically listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department or other facility • Skilled nursing facility	20% of charges
• Office	$20 per primary care visit $40 per specialist visit (No deductible)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is $500 per Self or $1,000 per Self and Family and applies to services when you pay a percentage of charges. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by a facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., doctors, etc.) are in Sections 5(a). or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Inpatient hospital	**High Option**
Room and board, such as: • ward, semiprivate, or intensive care accommodations • general nursing care • meals and special diets Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of charges
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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 • Diagnostic laboratory tests, x-rays, and pathology services • Colonoscopy when performed prior to age 50 or more often than once every 10 years (age 50 and over) 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. See Section 5(g). *Accidental injury* benefit.	20% of charges
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefits/skilled nursing care or other type of facility benefits: • 30-days per calendar year for confinement in an approved inpatient transitional care unit when ordered by a participating doctor. - bed, board and general nursing care (semi-private room) - drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the extended care/skilled nursing facility. Note: Maximum benefit payable for extended care benefits/skilled nursing care or other type of facility benefits is 30 days per person per calendar year.	20% of charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
Inpatient and outpatient hospice care Family counseling Note: These services are provided under the direction of a Plan doctor who certifies the patient to be terminally ill with six months or less to live. Note: Lifetime maximum benefit payable for Hospice care is 180 consecutive days per person.	20% of charges
Not covered: • *Funeral arrangements* • *Pastoral bereavement or legal counseling* • *Respite care* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate Note: Non-emergency ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved in advance by PHP.	20% of charges

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $500 per Self or $1,000 per Self and Family and applies to services when you pay a percentage of charges. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (for example, the 911 telephone system) or go to the nearest hospital room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$20 per primary care visit $40 per specialist visit (No deductible)
• Emergency care at an urgent care center	$40 per urgent care center visit (No deductible)
• Emergency room care at a hospital, including doctors' services	$300 per hospital emergency room visit (No deductible)

Emergency within our service area - continued on next page

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area (cont.)	**High Option**
Note: You are responsible for 20% of inpatient and certain outpatient hospital services such as labs and x-rays. See Sections 5(a)., 5(b)., and 5 (c).	$300 per hospital emergency room visit (No deductible)
Not covered: • *Elective care or non-emergency care* • *All follow-up care not approved by the Plan or provided by a Plan provider*	*All charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office	$20 per primary care visit $40 per specialist visit (No deductible)
• Emergency care at an urgent care center	$40 per urgent care center visit (No deductible)
• Emergency room care at a hospital, including doctors' services Note: You are responsible for 20% of inpatient and certain outpatient hospital services such as labs and x-rays. See Sections 5(a)., 5(b)., and 5 (c).	$300 per hospital emergency room visit (No deductible)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *All follow-up care not approved by the Plan or provided by a Plan provider*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: Non-emergency or air ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved by PHP.	20% of 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 or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
  - You must use a Plan provider and show them your ID card.
  - Your Plan provider will contact PHP for all services including precertification.
  - We list mental health and substance abuse Plan providers in the Provider Directory that we update periodically. This list is also on our website: www.phpni.com.
  - Services requiring prior authorization:
    - Inpatient Services: Behavioral Health.
    - Outpatient Services: Behavioral Health Testing; ECT Therapy; IOP Partial Behavioral Health; Pervasive Development Disorders (PDD) Services (treatment plan required).
- To obtain more information about our benefits or to obtain a Provider Directory, contact us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired; or through our website at www.phpni.com.
- 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 After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	**High 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.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes	$20 per visit for services performed in a doctor's office; otherwise 20% of charges

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	**High Option**
• 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	$20 per visit for services performed in a doctor's office; otherwise 20% of charges
Diagnostics	**High 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	20% of charges
Inpatient hospital or other covered facility	**High 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	20% of charges
Outpatient hospital or other covered facility	**High 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	20% of charges
Not Covered	**High Option**
• *Services that are not part of a preauthorized approved treatment plan*	*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.
- The calendar year deductible does not apply to prescription drug benefits.
- Some prescription drugs require approval or step therapy before we provide benefits for them. Please refer to the pre-authorization information shown 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.

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 may fill the prescription at a Plan pharmacy or by mail from the Plan's mail-order pharmacy.
- **We use a formulary.** A formulary is a list of prescription drugs that PHP encourages doctors to prescribe when appropriate. PHP develops this formulary with the help of PHP doctors. Doctors can prescribe any medication they choose. We cover non-formulary drugs prescribed by a doctor. However, if the drug is non-formulary, patients may have a higher copayment. We encourage you to discuss with your Plan doctor the medications being prescribed to you. Plan doctors may submit a prior authorization form to PHP for review if a formulary medication has not worked for you in the past. If approved, the brand name formulary copayment will apply. You are to confirm with your doctor the determination of PHP's review.
- We have an open formulary. If your doctor believes a name brand product is necessary or there is no generic available, your doctor may prescribe a name brand drug from our formulary list. The brand name formulary copayment will apply. 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 formulary brochure, call (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired; or visit our website at www.phpni.com (click on Pharmacy icon).
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you - and us - less than a name brand prescription.
- A generic equivalent will be dispensed if it is available, unless your doctor specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your doctor 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 as well as the applicable copay.
- **These are the dispensing limitations**. Generally, prescribed drugs will be dispensed for up to a 30-day supply or 240 milliliter of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin) unless limited by drug manufacturer's packaging per prescription, order, or refill.

- If you use certain Prescription Drugs on an extended basis, you may wish to obtain larger quantities through the Plan's mail-order benefit. Through mail-order, you may obtain up to a 90-day supply. Your refill order may be rejected if you send it too soon after the previous one was filled. For example, 80% of your prescription order needs to be used before it can be resubmitted for refill. If you are in the military and you are called to active duty, please contact us if you need assistance filling your prescription before your departure.
- **We cover certain prescription drugs in limited quantities.** Such drugs include but are not limited to: Viagra, Muse, and Caverject. Please contact the Plan for dosage limits.
- **Pre-authorization** is required for certain medications. If your physician wants to prescribe one, he or she will submit a preauthorization request to PHP before the drug is dispensed. Such drugs include but are not limited to: nail fungus treatments, growth hormone, multiple sclerosis medications and those medications that cost over $1,500 per prescription. If we receive the pre-authorization request during the normal working hours, we will try to respond to the request the same day or within 48 hours.
- **Step Therapy.** Our step therapy prior authorization program ensures that we cover the most cost effective medication that is appropriate for your use. Currently, asthmatic, anti-inflammatory, and antidepressant medications must be prior authorized by PHP through the Step Therapy program. This means that you will need to have tried one or more first-line drugs before we will cover the more costly alternative. Our step therapy prescription drug products and processes are subject to periodic review and modification.
- **Specialty Drugs**. We have a list of specialty drugs that have specific characteristics, such as but not limited to: generally injectable; high in cost; special handling requirements; and/or require special training in order to use. These drugs must be authorized by us and purchased at our participating vendor. These drugs are directed to treat conditions related to growth hormone therapy, hepatitis c, certain cancer therapies, multiple sclerosis, psoriasis, and rheumatoid arthritis. Our specialty drug products and processes are subject to periodic review and modification.
- Note: Call (260) 432-6690, extension 11, for preauthorization for Growth Hormone Therapy (GHT). We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services *requiring our prior approval* in Section 3. Plan doctor will periodically review the program for continuing appropriateness and need.
- **When you do have to file a claim.** If you are out of the area and have an emergency where there is no Plan pharmacy, then you may have to pay for the prescription and send the Plan a letter of explanation with your receipt.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan doctor and obtained from a Plan pharmacy: • Diabetic supplies • Drugs and medicines that by Federal law of the United States require a doctor's prescription for their purchase • Insulin (with a copayment applied to two vials) • Disposable needles and syringes needed to inject prescribed diabetes medications • Supplemental Feedings for metabolic disorders such as: Phenylketonuria (PKU) and Tyrosanemia Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable contraceptive drugs are covered under Section 5(a).	30 Days Supply - $10 generic per prescription unit; $30 brand name formulary per prescription unit; $60 brand name non-formulary per prescription unit 90 Days Supply - $30 generic per prescription unit; $90 brand name formulary per prescription unit; $180 brand name non-formulary per prescription unit

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Mail-order: Up to a 90-day supply of **certain** prescription maintenance drugs that you use on an extended basis. Note: Nail fungus drugs, infertility drugs, and sexual dysfunction drugs are not available through the mail-order program.	$20 generic per prescription unit $75 brand name formulary per prescription unit $180 brand name non-formulary per prescription unit
Specialty pharmacy medications such as but not limited to: Actemra; Acthar HP Gel; Amevive; Ampyra (oral); Aranesp; Arixtra; Aubagio (oral); Avonex; Betaseron; Cimzia; Copaxone; Copegus (oral); Enbrel; Epogen; Extavia; Forteo; Fragmin, Genotropin; Geref Diagnostic; Gilenya; Humatrope; Humira; Incivek (oral); Increlex; Infergen; Intron-A; Iprivask; Kineret; Leukine; Lovenox; Mozobil; Neulasta; Neupogen; Norditropin; Novantrone; Nplate; Nutropin AQ; Omnitrope; Orencia; Pegasys; Peg-Intron; Procrit; Promacta (oral); Protropin; Rebetrol (oral generics); Rebiff; Remicade; Rituxan; Roferon-A; Saizen; Sandostatin; Serostim; Simponi; Soliris vials; Somatuline; Stelara; Tecfidera (oral); Tev-Tropin; Tysabri; Victrelis (oral); Xeljanz (oral); Xolair and Zorbtive. We periodically review and update the list of specialty medications. Please contact us to verify if your drug is on the specialty drug list. Specialty drugs have specific characteristics, such as but not limited to: • generally injectable; • high in cost; • special handling requirements; and/or • require special training in order to use. Note: We must authorize all specialty pharmacy medications in advance and you must purchase them from our participating specialty drug vendor.	$250 maximum per prescription drug for up to a 30-days supply unless limited by drug manufacturer's packaging per prescription, order, or refill.
Specialty drugs for cancer chemotherapy treatment	$30 brand name formulary per presciption unit
Women's contraceptive drugs and devices Note: This excludes items and services for men, such as vasectomies, and over-the-counter contraceptive drugs and devices which includes condoms. Note: The morning after pill is considered preventive service under over-the-counter emergency contraceptives. There will be no cost to the member when prescribed by a physician and purchased at a network pharmacy.	Nothing (No deductible)
All Infertility drugs Note: Up to a consecutive 14-day supply of medication, unless limited by drug manufacturer's packaging per prescription, order, or refill. Fertility drugs are not available through the mail-order program.	20% of charges

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Note: Maximum benefit payable for infertility drugs is $1,500 per person per calendar year. Note: We cover certain infertility services under the *Infertility services benefit*. (See Section 5(a).)	20% of charges
Sexual dysfunction prescription drugs Note: We limit these prescription drugs to a 6-dose supply per month. Note: Maximum benefit payable for sexual dysfunction drugs is $1,000 per person per calendar year. Note: We cover certain durable medical equipment to treat sexual dysfunction. (See Section 5(a). *Durable medical equipment*)	20% of charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Vitamins, nutrients and food supplements even if a Plan doctor prescribes or administers them, except for supplemental feedings for metabolic disorders with the exclusion of Vitamin D which is covered for adults age 65 and older.* • *Nonprescription medicines* • *Drugs and products used for weight loss or appetite suppression unless prescribed for narcolepsy or hyperkinesias* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 39.)*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- The calendar year deductible is: $500 per Self or $1,000 per Self and Family. The calendar year deductible applies to all benefits in this Section.
- 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 services unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover emergency dental treatment necessary to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth, if such treatment occurs within 24-hours of the accidental injury.	Your cost sharing responsibility is determined by the specific service. See the applicable benefits section for more information. For example, see Section 5(d). for Emergency benefits information.
Not covered: • *Injury to the teeth caused by eating, chewing, or biting.* • *Any charges for services that are beyond the first 24 hours of accidental injury.* • *Temporary prosthetics including but not limited to:* - *partial or full dentures or bridges or* - *replacement prosthesis* - *manipulative, corrective or cosmetic adjustments of the teeth* - *orthodontia services* • *Any other dental services*	*All charges*
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Services for deaf and hearing impaired	A Telecommunication Device for the Deaf (TDD) is available for the deaf and hearing impaired by calling PHP at (260) 459-2600.
High risk pregnancies	PHP case managers will work with your Plan doctor to coordinate services necessary for the management of your high-risk pregnancy. A PHP case manager could contact you to discuss your medical needs, services available, and to answer benefit questions.
Centers of excellence	When your Plan doctor contacts PHP regarding your transplantation, a PHP case manager will provide beneficial information regarding PHP's Designated Transplant Facilities. A PHP case manager will contact you or your designee to coordinate your care and answer benefit questions related to your transplant.
Travel benefit/services overseas	You will have coverage for emergency services while traveling. Please refer to Section 5(d). for benefit information. If overseas, you may be required to pay for services rendered. If submitting to PHP for payment, you will need to have your itemized bills and receipts converted to U.S. currency (if applicable), provide an explanation of the services, and include member information from your ID card, for payment consideration.

Section 5. High Deductible Health Plan Benefits

See page 125 for a benefits summary. This benefits section is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. 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 our benefits, contact us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired, or on our website at www.phpni.com.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; or 260-459-2600 for the hearing impaired or on our website at www.phpni.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 71. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. Most services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care. You do not have to meet the deductible before using these services.*

- **Traditional medical coverage**

  After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 20% for in-network.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see 64 for more details).

Health Savings Accounts (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2015, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $41.67 per month for a Self Only enrollment or $83.34 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,350 for an individual and $6,650 for a family. See maximum contribution information on page 119. You can use funds in your HSA to help pay your health plan deductible**.** You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Your HSA is administered by
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a **HCFSA** health care flexible spending account (such as FSAFEDS offers – see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example, you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2015, we will give you an HRA credit of $500 per year for a Self Only enrollment and $1000 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by .

- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5000 per Self or $10,000 per Self and Family enrollment. Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Section 5. Savings - HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Old National Bank, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS.)	PHP is the HRA fiduciary for this Plan.
Fees	Set-up fee is waived.	None.
Eligibility	You must: • Enroll in this HDHP • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA and/or Indian Health Services (IHS) benefits in the last three months • Complete and return all banking paperwork	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2015, a monthly premium pass through of $41.67 will be made by the HDHP directly into your HSA each month.	For 2015, your HRA annual credit is $500 (prorated for mid-year enrollment).
• **Self and Family enrollment**		For 2015, your HRA annual credit is $1,000 (prorated for mid-year enrollment).

	For 2015, a monthly premium pass through of $83.34 will be made by the HDHP directly into your HSA each month.	
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,350 for an individual and $6,650 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). Catch-up contribution discussed on page 119.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
• **Self Only enrollment**	You may make an annual maximum contribution of $2,849.96.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $5,649.92.	You cannot contribute to the HRA.
Access Funds	You can access your HSA by the following methods: • Debit card • Withdrawal form • Checks - (cost is $20 for 30 checks)	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as orthodontia, a reimbursement form will be sent to you upon your request.
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed:	The entire amount of your HRA will be available to you upon your enrollment in the HDHP.

	• Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 64 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions** — If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.ustreas.gov/offices/public-affairs/hsa/.
- **If you die** — If you have not named beneficiary, and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.
- **Qualified expenses** — You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, **physician prescribed** over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.
- **Non-qualified expenses** — You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- **Tracking your HSA balance** — You will receive a periodic statement that shows the "premium pass through", withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA** — You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established** — If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.
- **How an HRA differs** — Please review the chart on page 64 which details the differences between an HRA and an HSA. The major differences are:
  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible except for eye exams and hearing exams for children.
- You must use providers that are part of our network.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*.

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Routine Annual Physical • Total Blood Cholesterol • Colorectal Cancer Screening, including: - Fecal occult test (one test every year for adults ages 50 to 75) - Sigmoidoscopy screening — every five years starting at age 50 - Colonoscopy screening (one screening every ten years starting at age 50 to 75) • Routine Prostate Specific Antigen (PSA) test • Routine Urinalysis Note: Maximum benefit payable for routine screenings listed above is one each per person per calendar year that we pay in full unless otherwise noted.	Nothing (No deductible)
Well woman care, including but not limited to: • Routine Pap test (one test every three years for women ages 21 to 65) • Routine mammogram (one test per year) • 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 (No deductible)
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) in the doctor's office.	Nothing (No deductible)
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/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons*	*All charges*

Benefit Description	You pay
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child visits for routine examinations and care (up to age 22)	Nothing (No deductible)
• Eye exams for children through age 17 to determine the need for vision correction	20% of charges
• Hearing exams for children through age 17 to determine the need for hearing correction	20% of charges
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/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons* • *Eyeglasses, contacts, or related supplies* • *Eye exercises*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

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.
- Most In-network preventive care is covered at 100% (see page 69) and is not subject to the calendar year deductible.
- The deductible is $2,000 per person or $4,000 per family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance for covered expenses.
- When you use network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance and deductibles total $5,000 per person or $10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services from network providers.
- 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 After the calendar year deductible...
Deductible before Traditional medical coverage begins	
You must satisfy your deductible before your Traditional medical coverage begins. The Self and Family deductible can be satisfied by one or more family members.	100% of charges until you meet the deductible of $2000 per Self or $4000 per Self and Family enrollment
Once your Traditional medical coverage begins and your deductible has been satisfied, you will be responsible for your coinsurance amounts for eligible medical expenses until you reach the annual catastrophic out-of-pocket maximum. At that point, we pay eligible medical expenses for the remainder of the calendar year at 100%.	After you meet the deductible, you pay 20% coinsurance for any covered services up to your annual catastrophic out-of-pocket maximum of $5000 per Self or $10,000 per Self and Family. You may choose to pay the coinsurance from your HSA or HRA, or you can pay for them 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.
- The calendar year deductible is: $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 After the calendar year deductible...
Diagnostic and treatment services	**HDHP**
Professional services of physicians as follows: • Office medical consultations • Second surgical opinion	20% of charges
Professional services of physicians • In an urgent care center	20% of charges
Professional services of physicans • During a hospital stay • In an extended care or skilled nursing facility • Outpatient diagnostic or surgical care	20% of charges
At home	20% of charges
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons* • *Professional services that are subject to exclusion*	*All charges*
Lab, X-ray and other diagnostic tests	**HDHP**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms	20% of charges

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

Benefit Description	You pay After the calendar year deductible...
Lab, X-ray and other diagnostic tests (cont.)	**HDHP**
• CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% of charges
Maternity care	**HDHP**
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	20% of charges
Breastfeeding support, supplies and counseling for each birth	Nothing (No deductible)
Note: Here are some things to keep in mind: • 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. Circumcision is covered as a surgical procedure. See Section 5(b). *Surgical benefits.* • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
• Labs, sonograms, fetal stress tests, etc., not included in the global fee	20% of charges
Specialized obstetrical services such as: • Aminocentesis • Corionic Villi Sampling	20% of charges
Family planning	**HDHP**
Contraceptive counseling on an annual basis	Nothing (No deductible)
A range of voluntary family planning services, limited to: • Voluntary sterilization (See *Surgical procedures* Section 5(b).) • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	20% of charges
Surgically implanted contraceptive such as Norplant	20% of charges

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible...
Family planning (cont.)	**HDHP**
Note: Norplant is considered a commonly used "surgically" implanted device. Maximum benefit payable for Norplant is one implant per person every five calendar years.	20% of charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	**HDHP**
Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Note: We cover up to a 14-day supply of infertility medicines unless limited by drug manufacturer's packaging, per prescription or refill under the *Prescription drug benefit* (See Section 5(f).). Maximum benefit payable for Infertility drugs is $1,500 per person per calendar year. The calendar year maximum applies to all infertility drugs including those medications purchased at a pharmacy or injected in your physician's office.	20% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**HDHP**
Testing	20% of charges
Treatment	20% of charges
Allergy injection Allergy serum	Nothing if you receive these services during your office visit; otherwise, 20% of charges
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*

Benefit Description	You pay After the calendar year deductible...
Treatment therapies	**HDHP**
Cancer Chemotherapy Treatment We will cover cancer chemotherapy treatment when ordered by and provided by a Plan Provider.	20% of charges
• Chemotherapy and radiation therapy • Dialysis - hemodialysis and peritoneal dialysis • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under *Organ/ Tissue Transplants*. Note: Respiratory and Inhalation therapy, home intravenous (IV) therapy, and antibiotic therapy are covered as *Home health services*. Note: We cover growth hormone therapy (GHT) under the *Prescription drug benefits*. We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on page 18.	20% of charges
Not covered: Experimental, investigational or unproven services, treatments, supplies, drugs, devices, and procedures	*All charges*
Inpatient/Outpatient Short Term Rehab/Habilitation Services	**HDHP**
• 20 visits per calendar year: - Physical therapy - Occupational therapy - Speech therapy - Pulmonary rehabilitation • 36 visits per calendar year: - Cardiac rehabilitation • 12 visits per calendar year: - Manipulation therapy Coverage is not provided for Therapy Services (Habilitation Services) treating chronic conditions for which there is no reasonable expectation of significant improvement. As explained in more detail below, We will Cover certain Therapy Services (Habilitation Services) that: A. are ordered by a Par Doctor; B. are provided by a Par Provider or Par Facility;	20% of charges

Inpatient/Outpatient Short Term Rehab/Habilitation Services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient/Outpatient Short Term Rehab/Habilitation Services (cont.)	**HDHP**
C. will result, in the judgment of a Par Doctor and PHP, in a significant improvement of Your condition within two months after the start of such services; and D. are Medically Necessary. Coverage provided under this benefit is limited to the following: **Physical Medicine Therapy Services** A. **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. B. **Speech therapy** for the correction of a speech impairment. C. **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.	20% of charges

Inpatient/Outpatient Short Term Rehab/Habilitation Services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient/Outpatient Short Term Rehab/Habilitation Services (cont.)	**HDHP**
D. **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered. Experimental, Investigational and Unproven Services, such as but not limited to: VAXD; Lordex; ART; DRS; and posture pump are not Covered. **Other Therapy Services** A. **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered. Such cardiac rehabilitation must meet Our guidelines to be Covered. B. **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.	20% of charges
Not covered: • *Long-term rehab therapy* • *Exercise programs* • *Developmental therapies*	*All charges*
Hearing services (testing, treatment, and supplies)	**HDHP**
• Hearing exam • Hearing testing for children, see Preventive care, children	20% of charges
Not covered: Hearing aids and supplies	*All charges*

Benefit Description	You pay After the calendar year deductible...
Vision services (testing, treatment, and supplies)	**HDHP**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing (No deductible)
• One routine eye exam for members age 18 and older every twelve months • Unlimited eye exams for children through age 17	20% of charges
Not covered: • *Eyeglasses, contact lenses, or related supplies, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Replacements for lenses during the same calendar year the lenses were provided due to accidental ocular injury or intraocular surgery (such as cataracts)*	*All charges*
Foot care	**HDHP**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	20% of charges
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*
Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies	**HDHP**
• Artificial eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacement, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c). for payment information. See 5(b). for coverage of the surgery to insert the device Rental up to purchase price, or purchase at our option, of durable medical equipment prescribed by your Plan doctor. Under this benefit, we also cover: • oxygen • dialysis equipment	20% of charges

Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies (cont.)	**HDHP**
• hospital beds • wheelchairs • crutches • walkers • audible prescription reading devices • blood glucose monitors • insulin pumps • orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, if we approve them in advance • ostomy supplies Note: Call us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired as soon as your Plan doctor 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 services when you call. Note: A separate maximum applies to Durable Medical Equipment to treat sexual dysfunction. Note: Ostomy Supplies are covered when used for the care of an artificial stoma or opening into the urinary, gastrointestinal canal and/or the trachea. 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% of charges
• Prosthetic arm, hand, leg or foot. Includes the orthotic device that is part of the prosthesis	20% of charges
• Custom molded foot orthotics to be placed in shoes if ordered and/or provided by a Plan doctor Note: Orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, under *Durable medical equipment*, if we approve them in advance. (See Section 5(a).)	20% of charges
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) dysfunction Note: This benefit service is in combination with other TMJ services. *See Oral and maxillofacial surgery.*	20% of charges
Durable Medical Equipment to treat sexual dysfunction such as but not limited to: • penile implants • vacuum pumps	20% of charges

Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices, durable medical equipment (DME) and ostomy supplies (cont.)	**HDHP**
Note: Maximum benefit payable for covered sexual dysfunction durable medical equipment is $1,000 per person per calendar year. Separate maximums apply to general durable medical equipment and ostomy supplies. Note: We cover certain drugs to treat sexual dysfunction under the Prescription drug benefits. See Section 5(f). Covered prescription drugs are subject to a separate $1,000 benefit maximum.	20% of charges
Not covered: • *Orthopedic and corrective shoes* • *Foot orthotics* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair or replacement of any non-medically necessary prosthetic devices* • *Motorized wheelchairs, scooters, lifts for wheelchairs; or motor vehicles* • *Repair or replacement of any non-medically necessary DME* • *Batteries to operate DME* • *Common household articles such as: air conditioners, humidifiers, and air purifiers* • *Disposable or non-durable medical supplies such as: elastic bandages, elastic support, and gauze*	*All charges*
Home health services	**HDHP**
• Home health care ordered by a Plan doctor and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide • Services include oxygen therapy, intravenous therapy, antibiotic therapy, and medications if provided by a Plan home health care agency Note: 90 days per calendar year limit. Services such as physical and occupational therapy or durable medical equipment are subject to coinsurance. See also *Physical and occupational therapies*, *Speech therapy*, and *Durable medical equipment (DME).*	20% of charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Home health services (cont.)	**HDHP**
• *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*
Alternative treatments	**HDHP**
• No benefit	*All charges*
Educational classes and programs	**HDHP**
Coverage is provided for: • Tobacco Cessation program, including two (2) quit attempts per year with up to four (4) smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling and individual counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for four (4) counseling sessions for up to two (2) quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
Coverage is limited to diabetes self-management training, meeting these minimum requirements: • One visit after receiving a diagnosis of diabetes • One visit after receiving a diagnosis that: - represents a significant change in the patient's symptoms or condition; and - makes a change in self-management necessary. • One visit for refresher or re-education training	20% of charges

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is $2,000 for Self only enrollment or $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 cover*age, including with Medicare.
- The services listed below are for the charges billed by a Plan 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 pre-certification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	**HDHP**
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*) • Circumcision (see *Maternity care*) • Surgical treatment of morbid obesity - a medical condition in which an individual has a body mass index (BMI) of at least 35 with co-morbidities, such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes mellitus or a BMI of 40 without co-morbidities. See note below. • Insertion of internal prosthetic devices. See 5(a). - *Orthopedic and prosthetic devices* for device coverage information such as: artificial knuckles and joints, pacemakers, insulin pump, defibrillator. See note below. • Voluntary sterilization (e.g. Tubal ligation, Vasectomy) • Treatment of burns	20% of charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	**HDHP**
Note: We cover non-experimental, surgical treatment of morbid obesity that has persisted for at least five (5) years and you have received non-surgical treatment supervised by a doctor for at least 18 consecutive months that has been unsuccessful. 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.	20% of charges
Not covered: *• Reversal of voluntary sterilization* *• Routine treatment of conditions of the foot. (See Foot care)*	*All charges*
Reconstructive surgery	**HDHP**
• 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, webbed fingers, and webbed toes.	20% of charges
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - 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.	20% of charges
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* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay After the calendar year deductible...
Oral and maxillofacial surgery	**HDHP**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	20% of charges
• Treatment for services of Temporomandibular joint dysfunction (TMJ) Note: Limited to one treatment per side of head per lifetime. This benefit service is in combination with all TMJ services.	20% of charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Treatment of overbite or underbite, maxillary and mandibular osteotomies, dental x-rays, dental supplies, and appliances and all associated expenses* • *Orthodontic treatment or braces for teeth*	*All charges*
Organ/tissue transplants	**HDHP**
These **solid organ transplants** are covered. These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • 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	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% of charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • 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 - 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	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- Severe or very severe aplastic anemia - Sickle cell 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 - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Waldenstrom's macroglobulinemia	20% of charges
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 - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- 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	20% of charges
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 - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - 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 - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Multiple sclerosis - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous Transplants for - Advanced Ewing sarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	**HDHP**
- Epithelial Ovarian Cancer - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasm) - Mantle Cell (Non-Hodgkin's lymphoma)	20% of charges
We use National Transplant Programs (NTP) - United Resource Networks (URN) and Interlink. Transplant services must be provided and arranged by a Plan doctor and performed at a designated transplant facility.	20% of charges
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.	20% of charges
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not specifically listed as covered*	*All charges*
Anesthesia	**HDHP**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department or other facility • Skilled nursing facility	20% of charges
• Office	20% of charges

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 a facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., doctors, 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 After the calendar year deductible...
Inpatient hospital	**HDHP**
Room and board, such as: • ward, semiprivate, or intensive care accommodations • general nursing care • meals and special diets Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of charges
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	**HDHP**
• *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when medically necessary*	*All charges*
Outpatient hospital or ambulatory surgical center	**HDHP**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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 • Diagnostic laboratory tests, x-rays, and pathology services • Colonoscopy when performed prior to age 50 or more often than once every 10 years (age 50 and over) 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. See Section 5(g). *Accidental injury benefit.*	20% of charges
Not covered: Blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**HDHP**
Extended care benefits/skilled nursing care or other type of facility benefits: • 30-days per calendar year for confinement in an approved inpatient transitional care unit when ordered by a participating doctor. - bed, board and general nursing care (semi-private room) - drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the extended care/skilled nursing facility. Note: Maximum benefit payable for extended care benefits/skilled nursing care or other type of facility benefits is 30 days per person per calendar year.	20% of charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Hospice care	**HDHP**
Inpatient and outpatient hospice care Family counseling Note: These services are provided under the direction of a Plan doctor who certifies the patient to be terminally ill with six months or less to live. Note: Lifetime maximum benefit payable for Hospice care is 180 consecutive days per person.	20% of charges
Not covered: • *Funeral arrangements* • *Pastoral bereavement or legal counseling* • *Respite care* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*
Ambulance	**HDHP**
• Local professional ambulance service when medically appropriate Note: Non-emergency ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved in advance by PHP.	20% of charges

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $2,000 for Self Only enrollment or $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (for example, the 911 telephone system) or go to the nearest hospital room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible...
Emergency within our service area	**HDHP**
• Emergency care at a doctor's office	20% of charges
• Emergency care at an urgent care center	20% of charges
• Emergency room care at a hospital, including doctors' services Note: You are responsible for 20% of inpatient and certain outpatient hospital services such as labs and x-rays. See Sections 5(a)., 5(b)., and 5 (c).	20% of charges
Not covered: • *Elective care or non-emergency care* • *All follow-up care not approved by the Plan or provided by a Plan provider*	*All charges*
Emergency outside our service area	**HDHP**
• Emergency care at a doctor's office	20% of charges
• Emergency care at an urgent care center	20% of charges
• Emergency room care at a hospital, including doctors' services Note: You are responsible for 20% of inpatient and certain outpatient hospital services such as labs and x-rays. See Sections 5(a)., 5(b)., and 5 (c).	20% of charges
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *All follow-up care not approved by the Plan or provided by a Plan provider*	*All charges*
Ambulance	**HDHP**
Professional ambulance service when medically appropriate. Note: Non-emergency or air ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved by PHP.	20% of 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 or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
  - You must use a Plan provider and show them your ID card.
  - Your Plan provider will contact PHP for all services including precertification.
  - We list mental health and substance abuse Plan providers in the Provider Directory that we update periodically. This list is also on our website: www.phpni.com.
  - Services requiring prior authorization:
    - Inpatient Services: Behavioral Health.
    - Outpatient Services: Behavioral Health Testing; ECT Therapy; IOP Partial Behavioral Health; Pervasive Development Disorders (PDD) Services (treatment plan required).
- To obtain more information about our benefits or to obtain a Provider Directory, contact us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired; or through our website at www.phpni.com.
- 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 After the calendar year deductible...
Professional services	**HDHP**
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.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • 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	20% of charges

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...
Professional services (cont.)	**HDHP**
• 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	20% of charges
Diagnostics	**HDHP**
• 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	20% of charges
Inpatient hospital or other covered facility	**HDHP**
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	20% of charges
Outpatient hospital or other covered facility	**HDHP**
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	20% of charges
Not Covered	**HDHP**
• *Services that are not part of a preauthorized approved treatment plan*	*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.
- The deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or for eligible prescriptions.
- Some prescription drugs require approval or step therapy before we provide benefits for them. Please refer to the pre-authorization information shown 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.

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 may fill the prescription at a Plan pharmacy or by mail from the Plan's mail-order pharmacy.
- **We use a formulary.** A formulary is a list of prescription drugs that PHP encourages doctors to prescribe when appropriate. PHP develops this formulary with the help of PHP doctors. Doctors can prescribe any medication they choose. We cover non-formulary drugs prescribed by a doctor. However, if the drug is non-formulary, patients may have a higher copayment. We encourage you to discuss with your Plan doctor the medications being prescribed to you. Plan doctors may submit a prior authorization form to PHP for review if a formulary medication has not worked for you in the past. If approved, the brand name formulary copayment will apply. You are to confirm with your doctor the determination of PHP's review.
- We have an open formulary. If your doctor believes a name brand product is necessary or there is no generic available, your doctor may prescribe a name brand drug from our formulary list. The brand name formulary copayment will apply. 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 formulary brochure, call (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired; or visit our website at www.phpni.com (click on Pharmacy icon).
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you - and us - less than a name brand prescription.
- A generic equivalent will be dispensed if it is available, unless your doctor specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your doctor 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 as well as the applicable copay.

- **These are the dispensing limitations**. Generally, prescribed drugs will be dispensed for up to a 30-day supply or 240 milliliter of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin) unless limited by drug manufacturer's packaging per prescription, order, or refill.
- If you use certain Prescription Drugs on an extended basis, you may wish to obtain larger quantities through the Plan's mail-order benefit. Through mail-order, you may obtain up to a 90-day supply. Your refill order may be rejected if you send it too soon after the previous one was filled. For example, 80% of your prescription order needs to be used before it can be resubmitted for refill. If you are in the military and you are called to active duty, please contact us if you need assistance filling your prescription before your departure.
- **We cover certain prescription drugs in limited quantities.** Such drugs include but are not limited to: Viagra, Muse, and Caverject. Please contact the Plan for dosage limits.
- **Pre-authorization** is required for certain medications. If your physician wants to prescribe one, he or she will submit a preauthorization request to PHP before the drug is dispensed. Such drugs include but are not limited to: nail fungus treatments, growth hormone, multiple sclerosis medications and those medications that cost over $1,500 per prescription. If we receive the pre-authorization request during the normal working hours, we will try to respond to the request the same day or within 48 hours.
- **Step Therapy.** Our step therapy prior authorization program ensures that we cover the most cost effective medication that is appropriate for your use. Currently, asthmatic, anti-inflammatory, and antidepressant medications must be prior authorized by PHP through the Step Therapy program. This means that you will need to have tried one or more first-line drugs before we will cover the more costly alternative. Our step therapy prescription drug products and processes are subject to periodic review and modification.
- **Specialty Drugs**. We have a list of specialty drugs that have specific characteristics, such as but not limited to: generally injectable; high in cost; special handling requirements; and/or require special training in order to use. These drugs must be authorized by us and purchased at our participating vendor. These drugs are directed to treat conditions related to growth hormone therapy, hepatitis c, certain cancer therapies, multiple sclerosis, psoriasis, and rheumatoid arthritis. Our specialty drug products and processes are subject to periodic review and modification.
- Note: Call (260) 432-6690, extension 11, for preauthorization for Growth Hormone Therapy (GHT). We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3. Plan doctor will periodically review the program for continuing appropriateness and need.
- **When you do have to file a claim.** If you are out of the area and have an emergency where there is no Plan pharmacy, then you may have to pay for the prescription and send the Plan a letter of explanation with your receipt.

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	**HDHP**
We cover the following medications and supplies prescribed by a Plan doctor and obtained from a Plan pharmacy: • Diabetic supplies • Drugs and medicines that by Federal law of the United States require a doctor's prescription for their purchase • Insulin (with a copayment applied to two vials) • Disposable needles and syringes needed to inject prescribed diabetes medications • Supplemental Feedings for metabolic disorders such as: Phenylketonuria (PKU) and Tyrosanemia	20% of charges

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**HDHP**
Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable contraceptive drugs are covered under Section 5(a). Note: A 30 day supply or 90 day supply may be obtained at a retail pharmacy.	20% of charges
Mail-order: Up to a 90-day supply of **certain** prescription maintenance drugs that you use on an extended basis. Note: Nail fungus drugs, infertility drugs, and sexual dysfunction drugs are not available through the mail-order program.	20% of charges
Specialty pharmacy medications such as but not limited to: Actemra; Acthar HP Gel; Amevive; Ampyra (oral); Aranesp; Arixtra; Aubagio (oral); Avonex; Betaseron; Cimzia; Copaxone; Copegus (oral); Enbrel; Epogen; Extavia; Forteo; Fragmin, Genotropin; Geref Diagnostic; Gilenya; Humatrope; Humira; Incivek (oral); Increlex; Infergen; Intron-A; Iprivask; Kineret; Leukine; Lovenox; Mozobil; Neulasta; Neupogen; Norditropin; Novantrone; Nplate; Nutropin AQ; Omnitrope; Orencia; Pegasys; Peg-Intron; Procrit; Promacta (oral); Protropin; Rebetrol (oral generics); Rebiff; Remicade; Rituxan; Roferon-A; Saizen; Sandostatin; Serostim; Simponi; Soliris vials; Somatuline; Stelara; Tecfidera (oral); Tev-Tropin; Tysabri; Victrelis (oral); Xeljanz (oral); Xolair and Zorbtive. We periodically review and update the list of specialty medications. Please contact us to verify if your drug is on the specialty drug list. Specialty drugs have specific characteristics, such as but not limited to: • generally injectable; • high in cost; • special handling requirements; and/or • require special training in order to use. Note: We must authorize all specialty pharmacy medications in advance and you must purchase them from our participating specialty drug vendor.	20% of charges
Specialty drugs for cancer chemotherapy treatment	20% of charges
Women's contraceptive drugs and devices Note: This excludes items and services for men, such as vasectomies, and over-the-counter contraceptive drugs and devices which includes condoms. Note: The morning after pill is considered preventive service under over-the-counter emergency contraceptives. There will be no cost to the member when prescribed by a physician and purchased at a network pharmacy.	Nothing (No deductible)
All Infertility drugs	20% of charges

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**HDHP**
Note: Up to a consecutive 14-day supply of medication, unless limited by drug manufacturer's packaging per prescription, order, or refill. Fertility drugs are not available through the mail-order program. Note: Maximum benefit payable for infertility drugs is $1,500 per person per calendar year. Note: We cover certain infertility services under the *Infertility services benefit*. (See Section 5(a).)	20% of charges
Sexual dysfunction prescription drugs Note: We limit these prescription drugs to a 6-dose supply per month. Note: Maximum benefit payable for sexual dysfunction drugs is $1,000 per person per calendar year. Note: We cover certain durable medical equipment to treat sexual dysfunction. (See Section 5(a). *Durable medical equipment*)	20% of charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Vitamins, nutrients and food supplements even if a Plan doctor prescribes or administers them, except for supplemental feedings for metabolic disorders with the exclusion of Vitamin D which is covered for adults age 65 and older.* • *Nonprescription medicines* • *Drugs and products used for weight loss or appetite suppression unless prescribed for narcolepsy or hyperkinesias* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 81.)*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- The calendar year deductible is $2,000 for Self Only enrollment and $4,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 services unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Accidental injury benefit	**HDHP**
We cover emergency dental treatment necessary to relieve pain and stop bleeding as a result of an accidental injury to sound natural teeth, if such treatment occurs within 24-hours of the accidental injury.	Your cost sharing responsibility is determined by the specific service. See the applicable benefits section for more information. For example, see Section 5(d). for Emergency benefits information.
Not covered: • *Injury to the teeth caused by eating, chewing, or biting.* • *Any charges for services that are beyond the first 24 hours of accidental injury.* • *Temporary prosthetics including but not limited to:* - *partial or full dentures or bridges or* - *replacement prosthesis* - *manipulative, corrective or cosmetic adjustments of the teeth* - *orthodontia services* • *Any other dental services*	*All charges*

Benefit Description	You pay After the calendar year deductible...
Dental benefits	**HDHP**
We have no other dental benefits.	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**HDHP**
Services for deaf and hearing impaired	A Telecommunication Device for the Deaf (TDD) is available for the deaf and hearing impaired by calling PHP at (260) 459-2600.
High risk pregnancies	PHP case managers will work with your Plan doctor to coordinate services necessary for the management of your high-risk pregnancy. A PHP case manager could contact you to discuss your medical needs, services available, and to answer benefit questions.
Centers of excellence	When your Plan doctor contacts PHP regarding your transplantation, a PHP case manager will provide beneficial information regarding PHP's Designated Transplant Facilities. A PHP case manager will contact you or your designee to coordinate your care and answer benefit questions related to your transplant.
Travel benefit/services overseas	You will have coverage for emergency services while traveling. Please refer to Section 5(d). for benefit information. If overseas, you may be required to pay for services rendered. If submitting to PHP for payment, you will need to have your itemized bills and receipts converted to U.S. currency (if applicable), provide an explanation of the services, and include member information from your ID card, for payment consideration.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our website at www.phpni.com. Visit our on our website at www.phpni.com for information on: • General health topics • Links to health care news • Cancer and other specific diseases • Drugs/medication interactions • Kids' health • Patient safety information • Several helpful website links
Account management tools	Your balance will be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim. If you have an **HSA**: • You may access your account online at www.theHSAauthority.com. If you have an **HRA**: • Your HRA balance will be available online through www.phpni.com. • Your balance will also be shown on your EOB form.
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online at www.phpni.com. Pricing information for medical care is available at www.phpni.com. Pricing information for prescription drugs is available at www.phpni.com. Link to online pharmacy through www.phpni.com. Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.phpni.com.
Care support	Patient safety information is available online at www.phpni.com.

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 these guidelines. For additional information contact the Plan at (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired or through our website at www.phpni.com.

In keeping with the goal of providing preventive health maintenance, PHP offers the following programs free of charge to existing members:

- Smoking Cessation - a Chantix™ benefit program for members to aid in stopping smoking. Coverage for Chantix™ is for 6 months in a 12 month time period. A program called "GetQuit" is free of charge to those using Chantix™. Another free resource is available through the Indiana Quitline - 1-800-QUIT-NOW. For more information, please contact us (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired or through our website at www.phpni.com.
- Weight Loss - a reimbursement program for members who are concerned with weight loss. Your program must include a Plan doctor to monitor your weight loss. For more information, please contact us (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired or through our website at www.phpni.com.

Preventive dental care is an important part of health maintenance. However, PHP is unable to offer you dental benefits.

Section 6. General exclusions – services, drugs and supplies we do not cover

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- 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, hospital and prescription drug benefits

In most cases, Plan 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, contact us at (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired, or at our website at www.phpni.com.

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 Plan 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 Health Plan of Northern Indiana, Inc.**
- **Claims Department**
- **8101 West Jefferson Boulevard**
- **P. O. Box 2359**
- **Fort Wayne, Indiana 46804-2359**

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, 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 be able to 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.phpni.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 Customer Service Department by writing Physicians Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, IN 46804-4163 or calling (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired.

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

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

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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.

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
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 Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804-4163; 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 Plan physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), 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.

Step	Description
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.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, 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 file a lawsuit. 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 (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired, or through our website at www.phpni.com. 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 Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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, 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 do not 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: 1-800-325-0778) 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 (260) 432-6690, extension 11; (800) 982-6257, extension 11; (260) 459-2600 for the hearing impaired, or see our website at www.phpni.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's 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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services (for example, office visits).

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

Non-health related services such as assistance with activities of daily living or health related services that:

- Do not seek to cure;
- Are provided when the medical condition of the Member is not changing;
- Do not require administration by skilled, licensed medical personnel because a non-professionally qualified person can be trained to perform them.
- Custodial care that lasts 90 days or more is sometimes known as long-term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental or investigational service

The plan uses a variety of authoritative sources including: governmental regulatory agencies, scientific literature, medical experts and other recognized authorities in the medical field to determine whether medical procedures are experimental and/or investigational.

Group health coverage

The contract between PHP and the Office of Personnel Management for FEHB employees.

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

Health Services that are determined by PHP to be *all* of the following:

- medically appropriate and necessary to meet the Member's basic health needs;
- the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;
- accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate;
- required for reasons other than the comfort or convenience of the member or his or her doctor;
- of a demonstrated medical value in treating the condition of the Member; and
- consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

Morbid obesity A medical condition in which an individual has a body mass index (BMI) of at least 35 with co-morbidities such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes mellitus or a BMI of 40 without co-morbidities.

Never Event Foreign object retained after surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, falls and trauma, manifestations of poor glycemic control, and deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement.

Out of pocket maximum The maximum amount of copayments and coinsurance that a member must pay each calendar year before we will provide 100% coverage for certain eligible services.

Plan allowance Plan allowance is the amount we use to determine our payment and your copay and/or coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: in-network-contracted charges for Plan doctors/out-of-network the median reimbursement amount in PHP's judgment for such service in the geographical area where the service was rendered.

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

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

Primary Care Physician A physician of primary care practice areas of family practice, pediatrics, internal medicine, obstetrics and gynecology.

Specialist A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drugs We have a list of certain prescription drugs established by PHP that we must preauthorize and you must obtain from our specialty drug pharmacy vendor. PHP reviews and changes the list from time to time. Specialty drugs have the following characteristics: generally injectable; high in cost; special handling requirements; and or, require special training to use.

Step Therapy Certain prescription drugs identified as only available for coverage under the Plan when other prescription drugs identified by PHP as appropriate for use have first been utilized by the Member, within the prior specified number of days. The identified prescription drug products and the processes are subject to periodic review and modification.

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 Customer Service Department at (260) 432-6690, extension 11; (800) 982-6257, extension 11; or (260) 459-2600 for the hearing impaired. 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 Health Plan.

You

You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	Your calendar year deductible is $2,000 for Self only and $4,000 for Self and Family enrollment for in-network services.
Health Savings Account (HSA)	An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified medical services.
Health Reimbursement Arrangement (HRA)	An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional medical coverage begins after you satisfy your deductible. Your HRA Fund counts toward your deductible.
High Deductible Health Plan (HDHP)	An HDHP is a plan with a deductible of at least $1,300 for individuals and $2,600 for families for 2015, adjusted each year for cost of living.
Maximum HSA Contribution	For 2015, the annual statutory maximum contribution is $3,350 for Self Only enrollment and $6,650 for Self and Family enrollment.
Catch-Up HSA Contribution	For 2015, individuals age 55 or older may make a catch up contribution of $1,000.
Premium Contribution to HSA/HRA	The amount of money we contribute to your HSA on a monthly basis. In 2015, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $41.67 per month for Self Only and $83.34 per month for Self and Family. If you have the HRA, and are a current member or enrolled during Open Season, we contribute $500 for Self only or $1,000 for Self and Family enrollments at the beginning of the year. If you enroll after January 1, 2015, the amount contributed will be on a prorated basis.

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 $2,500 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: 1-800-952-0450.

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

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Summary of benefits for the High Option Plan - 2015

- **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.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.
- The calendar year deductible is $500 per person and $1000 per family.

Benefits	You pay	Page
Medical services provided by physicians:		
• Office visits	$20 per primary care visit $40 per specialist visit	27
• Diagnostic laboratory tests and other treatment services	20% of charges*	28
Services provided by a hospital:		
• Inpatient or Outpatient	20% of charges*	46
Emergency benefits:		
• In-area or Out-of-Area	$20 per primary care doctor's office visit; $40 per specialist's office visit; $40 per urgent care center visit; or $300 per hospital emergency room visit	49
Mental health and substance abuse treatment:	Regular cost-sharing*	51
Prescription drugs:		
• Up to a 30 day supply	$10 generic/$30 brand name formulary/ $60 brand name non-formulary per prescription unit or refill	54
• Up to a 90 day supply	$30 generic/$90 brand name formulary/ $180 brand name non-formulary per prescription unit or refill	
Mail-order drugs:		
• Up to a 90 day supply of medication	$20 generic/$75 brand name formulary/ $180 brand name non-formulary per prescription unit or refill	54
Specialty pharmacy drugs:	$250 maximum per prescription drug.	55
Dental care:		
• No benefit	All Charges	57
Vision care:		

Benefits	You pay	Page
• Limited to one annual eye refraction for members 18 and over	$40 per specialist visit	34
Protection against catastrophic costs: Medical - $4,000/Self Only or $8,000 Self and Family per year	Nothing for certain services as specified in the brochure	23

Summary of benefits for the High Deductible Health Plan - 2015

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.
- In 2015 for each month you are eligible for the Health Savings Account (the Plan will deposit $41.67 per month for Self Only enrollment or $83.34 per month for Self and Family enrollment to your HSA. For the HSA you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $2000 for Self Only and $4000 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $500 for Self Only and $1000 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

Benefits	You pay	Page
Medical services provided by physicians:		
• Office visits • Diagnostic laboratory tests and other treatment services	20% of charges*	72
Services provided by a hospital:		
• Inpatient or Outpatient	20% of charges*	89
Emergency benefits:		
• In-Area or Out-of-Area	20% of charges*	93
Mental health and substance abuse treatment:	20% of charges*	94
Prescription drugs:		
• Up to a 30 day or 90 day supply	20% of charges*	97
Mail-order drugs:		
• Up to a 90 day supply of medication	20% of charges*	98
Specialty pharmacy drugs:	20% of charges*	98
Dental care:		
• No benefit	All Charges	100
Vision care:		
• Limited to one annual eye refraction for members 18 and over	20% of charges*	78

Benefits	You pay	Page
Protection against catastrophic costs: Medical - $5,000/Self Only or $10,000 Self and Family per calendar year	Nothing for certain services as specified in the brochure	63

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.