

# Physicians Health Plan of Northern Indiana

<http://www.phpni.com>

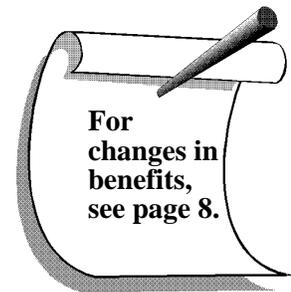


## 2007

### A Health Maintenance Organization

Serving: Northeast Indiana

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.**



**Important Special Notice For All Current Enrollees About Specialty Medication** Our coverage for specialty drugs has changed. You will pay 25% of the eligible expenses for specialty medication up to \$250 per prescription per month. Your out-of-pocket maximum for specialty drugs is \$2,500 per calendar year. Please read your brochure very carefully so that you are aware of this important benefit change.

**Enrollment codes for this Plan:**

- DQ1 Self Only
- DQ2 Self and Family

Authorized for distribution by the:



**United States  
Office of Personnel Management**  
Center for  
Retirement and Insurance Services  
<http://www.opm.gov/insure>



## **Important Notice from Physicians Health Plan of Northern Indiana**

### **About Our Prescription Drug Coverage and Medicare**

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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

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### **Please be advised**

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly 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'll 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 (November 15th through December 31st) 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](http://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](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Introduction

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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. 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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. Rates are shown at the end of this brochure.

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## Plain Language

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All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- 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 first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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## Stop Health Care Fraud!

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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.

- 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](http://www.phpni.com) and explain the situation.

If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## **Preventing medical mistakes**

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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 that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- 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 you are taking.

Visit these Web sites for more information about patient safety.

[www.ahrq.gov/path/beactive.htm](http://www.ahrq.gov/path/beactive.htm). 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](http://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/](http://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](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.

[www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

[www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1 Facts about this HMO plan

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### General features of our coverage

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 1,902 private practice doctors in all specialties at more than 1,053 locations. In addition, there are over 53,000 neighborhood participating pharmacies, 35 participating hospitals and over 34 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.**

### 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.

### 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 Web site ([www.opm.gov/insure](http://www.opm.gov/insure)) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- 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.

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 Web site at [www.phpni.com](http://www.phpni.com).

### 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, Jay, Huntington, Kosciusko, LaGrange, Noble, St. Joseph, 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.

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## Section 2 How we change for 2007

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

### Changes to this Plan

- Your share of the non-Postal premium will decrease by 11.8% for Self Only or by 12% for Self and Family.
- You will pay 25% coinsurance for specialty drugs up to a maximum of \$250 per prescription per month. The out-of-pocket maximum for specialty drugs is \$2,500 per person per calendar year for specialty drugs. This out-of-pocket maximum is separate from the medical out-of-pocket maximum. Previously, we applied the applicable prescription drug copay to all specialty medication. See page 38.
- The lifetime maximum for custom molded foot orthotics has increased from \$200 to \$500 per lifetime. See page 21.
- We have combined the annual maximum payable limit for durable medical equipment and ostomy supplies. The new combined annual maximum payable limit is \$5,000 per person per calendar year. Previously, the annual maximum limit was \$5,000 for durable medical equipment and \$500 for ostomy supplies. Please note that the annual maximum for durable medical equipment to treat sexual dysfunction has not changed and remains \$1,000 per member per calendar year. See page 21.
- Ambulance services will be subject to the annual deductible. Previously, these services were not subject to the annual deductible of \$250 per individual or \$500 per family. See page 32.
- We will no longer cover accidental injury dental services that you receive within 12 months of the date of an accidental injury to sound natural teeth. We will cover only those services that you receive within 24 hours to relieve pain and stop bleeding as a result of the accidental injury. See page 41.

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## Section 3 How you get care

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### 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 Web site at [www.phpni.com](http://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. 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 Web site: [www.phpni.com](http://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 Web site.

### 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 1,581 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; or
  - 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**

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 reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

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

**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.

**Services requiring our prior approval**

Your Plan physician must get our approval before sending you to a hospital for an inpatient stay, or referring you to a non-participating physician or facility. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Your doctor must obtain our approval for the following services:

- Bariatric Treatment
- Behavioral Health or Substance Abuse

- Bone Growth Stimulator
- Capsular Endoscopy (Given)
- Cochlear Implant
- Durable Medical Equipment
- Implantable Neurostimulator
- Inpatient Services, Skilled Nursing or Other Type of Facility
- Maternity
- Non-Emergency Ambulance Transportation
- Out-of-Area Physicians
- Penile Implants
- PET Scan
- Reconstructive Surgeries
- Sclerotherapy
- Sleep Studies
- Transplants
- Medications that Cost \$1,000 or More Per Prescription

Additional drugs requiring prior authorization include but are not limited to:

- Botox
- Immune Globulin
- Synagis
- Clotting Factor
- IVIG

The above list is subject to periodic review and modification.

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## Section 4 Your costs for covered services

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

### **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit.

### **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.

- The calendar year deductible for medical services is \$250 per person. 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 \$500.

### **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your 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**

After your coinsurance totals \$2,500 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay coinsurance for certain covered medical services. However, copayments and/or coinsurance for the following services do not count toward your medical catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Office Visits
- Well-child Care Charges for Routine Examinations, Immunization and Care
- Eye Examinations
- Urgent Care
- Infertility Treatment
- Temporomandibular Joint Disorder Treatment
- Ostomy Supplies
- Surgically Implanted Contraceptives
- Prescription Drugs
- Prosthetic and Orthotic Devices
- Emergency Room Charge
- Custom Molded Foot Orthotics
- Durable Medical Equipment to Treat Sexual Dysfunction
- Durable Medical Equipment

You have a separate out-of-pocket maximum for specialty drugs. The out-of-pocket maximum for specialty drugs is up to \$250 per prescription per month. The annual out-of-pocket maximum for specialty drugs is \$2,500 per person per calendar year. Once you have satisfied \$2,500 per person for specialty pharmacy medications, you will not have continued copayments for specialty medications for the remainder of the calendar year.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

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## Section 5 Benefits

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See page 8 for how our benefits changed this year and page 61 for a benefits summary. This benefits section is divided into subsections. Please read the 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 through our Web site at [www.phpni.com](http://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: \$250 per person or \$500 per 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.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay coinsurance for certain services. Some services do not count toward your catastrophic protection out-of-pocket maximum and you will continue to pay copays and/or coinsurance for those services. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more specific information.

Benefit Description	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b></p>	
<b>Diagnostic and treatment services</b>	
Professional services of physicians as follows: <ul style="list-style-type: none"> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$15 per office visit  (No deductible)
Professional services of physicians <ul style="list-style-type: none"> <li>• In an urgent care center</li> </ul>	\$30 per visit  (No deductible)
Professional services of physicians <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In an extended care or skilled nursing facility</li> <li>• Outpatient diagnostic or surgical care</li> </ul>	20% of Charges
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Professional services that are subject to exclusion</i></li> <li>• <i>Physicians visits in the home or house calls</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	20% of Charges
<b>Preventive care, adult</b>	
Routine screenings, such as: <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>- Fecal occult test</li> </ul> </li> <li>• Routine Prostate Specific Antigen (PSA) test</li> <li>• Routine Pap Test</li> <li>• Routine Mammogram</li> </ul> <p>Note: Maximum benefit payable for routine screenings listed above is one each per person per calendar year that we pay in full.</p>	Nothing (No deductible)
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) in the doctor's office such as: <ul style="list-style-type: none"> <li>• Influenza vaccine, annually</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	\$15 per office visit (No deductible)
Routine Colorectal Cancer Screening, including: <ul style="list-style-type: none"> <li>• Sigmoidoscopy, screening</li> </ul>	\$15 per office visit; otherwise, 20% of charges
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>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</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Preventive care, children</b>	
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunization and care</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>- Ear exams through age 17 to determine the need for hearing correction</li> <li>- Examinations done on the day of immunizations</li> </ul> </li> </ul>	\$15 per office visit  (No deductible)
<ul style="list-style-type: none"> <li>• Eye exams for children through age 17 to determine the need for vision correction</li> </ul>	\$20 per office visit  (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Eyeglasses, contacts, or related supplies</i></li> <li>• <i>Eye exercises</i></li> </ul>	<i>All charges.</i>
<b>Maternity care</b>	
<p>Complete Maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• Your Plan doctor will need to precertify your maternity services; see page 29 for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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) <i>Surgical benefits</i>.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) <i>Hospital benefits</i> and Section 5(b) <i>Surgical benefits</i>.</li> </ul>	\$15 for initial office visit only; 20% of charges thereafter
<ul style="list-style-type: none"> <li>• Labs, sonograms, fetal stress tests, etc., not included in the global fee</li> </ul>	20% of charges
<p>Specialized obstetrical services such as:</p> <ul style="list-style-type: none"> <li>• Aminocentesis</li> <li>• Corionic Villi Sampling</li> </ul>	\$15 per office visit when performed in the doctor's office; otherwise, 20% of charges

*Maternity care - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Maternity care (cont.)</b>	
<i>Not covered: Routine sonograms to determine sex.</i>	<i>All charges.</i>
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See <i>Surgical procedures</i> Section 5(b))</li> <li>• Injectable contraceptive drugs</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per office visit  (No deductible)</p>
<p>Surgically implanted contraceptive such as Norplant</p> <p>Note: Norplant is considered a commonly used "surgically" implanted device. Maximum benefit payable for Norplant is one implant per person every five calendar years.</p>	<p>40% of charges  (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary surgical sterilization</i></li> <li>• <i>Genetic counseling</i></li> </ul>	<i>All charges.</i>
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- intravaginal insemination (IVI)</li> <li>- intracervical insemination (ICI)</li> <li>- intrauterine insemination (IUI)</li> </ul> </li> </ul> <p>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 <i>Prescription drug benefit</i> (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.</p>	<p>40% of charges  (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i></li> <li>• <i>in vitro fertilization</i></li> <li>• <i>embryo transfer, gamete GIFT and zygote ZIFT</i></li> <li>• <i>zygote transfer</i></li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Allergy care</b>	
Testing and treatment	\$15 per office visit  (No deductible)
Allergy injection  Allergy serum	Nothing if you receive these services during your office visit; otherwise, \$15 per office visit  (No deductible)
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>
<b>Treatment therapies</b>	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> <li>• Dialysis - hemodialysis and peritoneal dialysis</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <p>Note: Respiratory and Inhalation therapy, home intravenous (IV) therapy, and antibiotic therapy are covered as <i>Home health services</i>. Please see page 23.</p> <p>Note: We cover growth hormone therapy under the <i>Prescription drug benefits</i>. Please see page 37.</p>	20% of charges
<i>Not covered: Experimental, investigational or unproven services, treatments, supplies, drugs, devices, and procedures</i>	<i>All charges.</i>
<b>Physical and occupational therapies</b>	
<ul style="list-style-type: none"> <li>• 62 visits per condition per calendar year for the services of each of the following: <ul style="list-style-type: none"> <li>- licensed physical therapists and</li> <li>- occupational therapists</li> </ul> </li> <li>• Cardiac rehabilitation</li> </ul> <p>Note: We only cover physical or occupational therapies to restore bodily function due to illness or injury for up to two months per condition if significant improvement can be expected. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p> <p>Note: Cardiac rehabilitation includes Phase I and Phase II treatments.</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehab therapy</i></li> <li>• <i>Exercise programs</i></li> <li>• <i>Developmental therapies</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Speech therapy</b>	
Up to 20 visits of speech therapy services per calendar year from a licensed therapist  Note: We cover habilitative or rehabilitative speech therapy.	\$15 when performed in the doctor's office; otherwise 20% of charges
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Developmental therapies</i></li> <li>• <i>Behavior disorder</i></li> <li>• <i>Stuttering/stammering</i></li> <li>• <i>Tongue thrust</i></li> </ul>	<i>All charges.</i>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Hearing exam</li> </ul>	\$15 per visit  (No deductible)
<i>Not covered: Hearing aids and supplies</i>	<i>All charges.</i>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</li> </ul>	Nothing  (No deductible)
<ul style="list-style-type: none"> <li>• One routine eye exam for members age 18 and older every twelve months</li> <li>• Unlimited eye exams for children through age 17</li> </ul>	\$20 per visit  (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Eyeglasses, contact lenses, or related supplies</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> <li>• <i>Replacements for lenses during the same calendar year the lenses were provided due to accidental ocular injury or intraocular surgery (such as cataracts)</i></li> </ul>	<i>All charges.</i>
<b>Foot care</b>	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes  See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.	\$15 per office visit  (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Orthopedic and prosthetic devices</b>	
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• 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</li> </ul> <p>Note: The combined maximum benefit payable for orthopedic and prosthetic devices is \$5,000 per person per calendar year. Prosthetic devices directly related to a covered mastectomy are not subject to the annual maximum.</p>	<p>20% of charges</p> <p>(No deductible)</p>
<ul style="list-style-type: none"> <li>• Custom molded foot orthotics to be placed in shoes if ordered and/or provided by a Plan doctor</li> </ul> <p>Note: No deductible.</p> <p>Note: Orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, under <i>Durable medical equipment</i>, if we approve them in advance. (See Section 5(a))</p> <p>Note: Lifetime maximum benefit payable for custom molded foot orthotics is \$500 per person.</p>	<p>40% of charges</p>
<ul style="list-style-type: none"> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) dysfunction</li> </ul> <p>Note: This benefit service is in combination with other TMJ services. See <i>Oral and maxillofacial surgery</i>.</p>	<p>40% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>Repair or replacement of any non-medically necessary prosthetic devices</i></li> </ul>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
<b>Durable medical equipment (DME)</b>	
<p>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:</p> <ul style="list-style-type: none"> <li>• oxygen;</li> <li>• dialysis equipment;</li> <li>• hospital beds;</li> <li>• standard wheelchairs;</li> <li>• crutches;</li> <li>• walkers;</li> <li>• blood glucose monitors;</li> <li>• insulin pumps;</li> <li>• orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, if we approve them in advance; and</li> <li>• ostomy supplies</li> </ul> <p>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 service when you call.</p> <p>Note: The combined maximum benefit payable for general durable medical equipment (including ostomy supplies) is \$5,000 per person per calendar year.</p> <p>Note: A separate maximum applies to Durable Medical Equipment to treat sexual dysfunction.</p> <p>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.</p>	<p>20% of charges (No deductible)</p>
<p>Ostomy Supplies</p> <p>Note: No deductible.</p> <p>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.</p> <p>Note: Maximum benefit payable for Ostomy Supplies is \$5,000 per person per calendar year. This benefit service maximum is combined with orthopedic and prosthetic devices (excluding those related to a mastectomy), and durable medical equipment. Separate maximums apply to durable medical equipment to treat sexual dysfunction.</p>	<p>20% of charges</p>
<p>Durable Medical Equipment to treat sexual dysfunction such as but not limited to:</p> <ul style="list-style-type: none"> <li>• penile implants</li> <li>• vacuum pumps</li> </ul>	<p>40% of charges</p>

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

Benefit Description	You pay After the calendar year deductible...
<b>Durable medical equipment (DME) (cont.)</b>	
<p>Note: No deductible.</p> <p>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.</p> <p>Note: We cover certain drugs to treat sexual dysfunction under the <i>Prescription drug benefits</i>. See Section 5(f). Covered prescription drugs are subject to a separate \$1,000 benefit maximum.</p>	40% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Motorized wheelchairs, scooters, lifts for wheelchairs, or motor vehicles</i></li> <li>• <i>Repair or replacement of any non-medically necessary DME</i></li> <li>• <i>Batteries to operate DME</i></li> <li>• <i>Common household articles such as: air conditioners, humidifiers, and air purifiers</i></li> <li>• <i>Disposable or non-durable medical supplies such as: elastic bandages, elastic support, and gauze</i></li> </ul>	<i>All charges.</i>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• 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</li> <li>• Services include oxygen therapy, intravenous therapy, antibiotic therapy, and medications if provided by a Plan home health care agency</li> </ul> <p>Note: Services such as physical and occupational therapy or durable medical equipment are subject to copayments or coinsurance. See also <i>Physical and occupational therapies, Speech therapy, and Durable medical equipment (DME)</i>.</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i></li> <li>• <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i></li> <li>• <i>Custodial care</i></li> </ul>	<i>All charges.</i>

Benefit Description	You pay After the calendar year deductible...
<b>Chiropractic</b>	
<ul style="list-style-type: none"> <li>• No benefit</li> </ul>	<i>All charges.</i>
<b>Alternative treatments</b>	
<ul style="list-style-type: none"> <li>• No benefit</li> </ul>	<i>All charges.</i>
<b>Educational classes and programs</b>	
<p>Coverage is limited to diabetes self-management training, meeting these minimum requirements:</p> <ul style="list-style-type: none"> <li>• One visit after receiving a diagnosis of diabetes</li> <li>• One visit after receiving a diagnosis that: <ul style="list-style-type: none"> <li>- represents a significant change in the patient's symptoms or condition; and</li> <li>- makes a change in self-management necessary.</li> </ul> </li> <li>• One visit for refresher or re-education training</li> </ul>	\$15 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 \$250 per person or \$500 per 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 Plan physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF 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.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay coinsurance for certain services. Some services do not count toward your catastrophic protection out-of-pocket maximum and you will continue to pay copays and/or coinsurance for those services. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more specific information.

Benefit Description	You pay After the calendar year deductible...
<b>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</b>	
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Circumcision (see <i>Maternity care</i>)</li> <li>• 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.</li> </ul>	<p>\$15 per office visit for surgery performed in the doctor's office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor's office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>

*Surgical procedures - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See 5(a) - <i>Orthopedic and prosthetic devices</i> for device coverage information such as: artificial knuckles and joints, pacemakers, insulin pump, defibrillator. See note below.</li> <li>• Voluntary sterilization (e.g. Tubal ligation, Vasectomy)</li> <li>• Treatment of burns</li> </ul> <p>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.</p> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per office visit for surgery performed in the doctor's office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor's office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot. (See Foot care)</i></li> </ul>	<p><i>All charges.</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member's appearance, and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• 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.</li> </ul>	<p>\$15 per office visit for surgery performed in the doctor's office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor's office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<ul style="list-style-type: none"> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- surgery to produce a symmetrical appearance on the other breast;</li> <li>- treatment of any physical complications, such as lymphedemas;</li> <li>- breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per office visit for surgery performed in the doctor's office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor's office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges.</i></p>

Benefit Description	You pay After the calendar year deductible...
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>\$15 per office visit for surgery performed in the doctor's office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor's office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<ul style="list-style-type: none"> <li>• Treatment for services of Temporomandibular joint dysfunction (TMJ)</li> </ul> <p>Note: This benefit service is in combination with all TMJ services.</p>	<p>40% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Treatment of overbite or underbite, maxillary and mandibular osteotomies, dental x-rays, dental supplies, and appliances and all associated expenses</i></li> <li>• <i>Orthodontic treatment or braces for teeth</i></li> </ul>	<p><i>All charges.</i></p>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/Lung</li> <li>• Kidney</li> <li>• Pancreas</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single - Double, Lobar</li> <li>• Intestinal transplant <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul> </li> </ul>	<p>\$15 per office visit; 20% of charges for transplant procedure</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Allogeneic transplants for:</p>	<p>\$15 per office visit; 20% of charges for transplant procedure</p>

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>• Acute lymphocytic leukemia or non-lymphocytic leukemia (i.e., myelogenous leukemia)</li> <li>• Advanced Hodgkin's lymphoma</li> <li>• Advanced non-Hodgkin's lymphoma</li> <li>• Chronic myelogenous leukemia</li> <li>• Severe combined immunodeficiency</li> <li>• Severe or very severe aplastic anemia</li> <li>• Phagocytic deficiency diseases (e.g., Wiskot-Aldrich syndrome)</li> <li>• Advanced forms of myelodysplastic syndromes</li> <li>• Infantile malignant osteopetrosis</li> <li>• Kostmann's syndrome</li> <li>• Leukocyte adhesion deficiencies</li> <li>• Mucopolysaccharidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)</li> <li>• Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)</li> <li>• Myeloproliferative disorders</li> <li>• Sickle cell anemia</li> <li>• Thalassemia major (homozygous beta-thalassemia)</li> <li>• Multiple Myeloma</li> </ul>	\$15 per office visit; 20% of charges for transplant procedure
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <p>Autologous transplants for:</p> <ul style="list-style-type: none"> <li>• Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>• Advanced Hodgkin's lymphoma</li> <li>• Advanced non-Hodgkin's lymphoma</li> <li>• Advanced neuroblastoma</li> <li>• Testicular mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>• Multiple myeloma</li> <li>• Amyloidosis</li> <li>• Ewing's sarcoma</li> </ul> <p>Autologous tandem transplants for:</p> <ul style="list-style-type: none"> <li>• Recurrent germ cell tumors (including testicular cancer)</li> </ul>	\$15 per office visit; 20% of charges for transplant procedure
<p>We cover the following transplants when you are accepted into a clinical trial sponsored by the National Cancer Institute or a nationally recognized organization, as part of a Phase II, III or IV clinical trial. The patient must be accepted into the clinical trial:</p> <p>Nonmyeloablative allogeneic transplants limited to the following diagnoses:</p>	\$15 per office visit; 20% of charges for transplant procedure

Benefit Description	You pay After the calendar year deductible...
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>• Acute lymphocytic or non-lymphocytic leukemia</li> <li>• Advanced forms of myelodysplastic syndromes</li> <li>• Advanced Hodgkin's lymphoma</li> <li>• Advanced non-Hodgkin's lymphoma</li> <li>• Breast cancer</li> <li>• Chronic myelogenous leukemia</li> <li>• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>• Multiple myeloma</li> <li>• Myeloproliferative disorders</li> </ul> <p>Allogeneic transplants limited to the following diagnosis:</p> <ul style="list-style-type: none"> <li>• Multiple myeloma</li> </ul> <p>Autologous transplants limited to the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Breast cancer</li> <li>• Epithelial ovarian cancer</li> </ul>	\$15 per office visit; 20% of charges for transplant procedure
<p>Note: 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.</p> <p>Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.</p>	\$15 per office visit; 20% of charges for transplant procedure
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs involving mechanical or animal origins</i></li> <li>• <i>Transplants not specifically listed as covered</i></li> <li>• <i>Solid organ transplants performed as a treatment for cancer</i></li> </ul>	<i>All charges.</i>
<b>Anesthesia</b>	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department or other facility</li> <li>• Skilled nursing facility</li> </ul>	20% of charges
<ul style="list-style-type: none"> <li>• Office</li> </ul>	\$15 per office 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 \$250 per person or \$500 per 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).
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay coinsurance for certain services. Some services do not count toward your catastrophic protection out-of-pocket maximum and you will continue to pay copays and/or coinsurance for those services. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more specific information.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
<b>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</b>	
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>• ward, semiprivate, or intensive care accommodations;</li> <li>• general nursing care; and</li> <li>• meals and special diets.</li> </ul> Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and x-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul> <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	20% of charges

*Inpatient hospital - continued on next page*

Benefit Description	You pay
<b>Inpatient hospital (cont.)</b>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes, schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care except when medically necessary</li> </ul>	<p><i>All charges.</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> <li>• Diagnostic laboratory tests, x-rays, and pathology services</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. See Section 5(h) <i>Accidental injury</i> benefit.</p>	<p>20% of charges</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges.</i></p>
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<p>Extended care benefits/skilled nursing care or other type of facility benefits:</p> <ul style="list-style-type: none"> <li>• 30-days per calendar year for confinement in an approved inpatient transitional care unit when ordered by a participating doctor. <ul style="list-style-type: none"> <li>- bed, board and general nursing care (semi-private room)</li> <li>- drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the extended care/skilled nursing facility.</li> </ul> </li> </ul> <p>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.</p>	<p>20% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Nursing care requested by, or for the convenience of, the patient or the patient's family</li> <li>• Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</li> <li>• Custodial care</li> </ul>	<p><i>All charges.</i></p>

Benefit Description	You pay
<b>Hospice care</b>	
<p>Inpatient and outpatient hospice care</p> <p>Family counseling</p> <p>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.</p> <p>Note: Lifetime maximum benefit payable for Hospice care is 60 consecutive days per person.</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Funeral arrangements</i></li> <li>• <i>Pastoral bereavement or legal counseling</i></li> <li>• <i>Respite care</i></li> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i></li> <li>• <i>Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i></li> <li>• <i>Custodial care</i></li> </ul>	<i>All charges.</i>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>• Local professional ambulance service when medically appropriate</li> </ul> <p>Note: Non-emergency ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved in advance by PHP.</p>	20% of charges

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## Section 5(d) Emergency services/accidents

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### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$250 per person or \$500 per 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.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay coinsurance for certain services. Some services do not count toward your catastrophic protection out-of-pocket maximum and you will continue to pay copays and/or coinsurance for those services. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more specific information.

### 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...
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$30 per urgent care center visit
<ul style="list-style-type: none"> <li>Emergency room care at a hospital, including doctors' services</li> </ul> <p>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).</p>	\$75 per hospital emergency room visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>All follow-up care not approved by the Plan or provided by a Plan provider</i></li> </ul>	<i>All charges.</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$30 per urgent care center visit
<ul style="list-style-type: none"> <li>Emergency room care at a hospital, including doctors' services</li> </ul> <p>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).</p>	\$75 per hospital emergency room visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> <li><i>All follow-up care not approved by the Plan or provided by a Plan provider</i></li> </ul>	<i>All charges.</i>
<b>Ambulance</b>	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: Non-emergency or air ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved by PHP.</p>	20% of charges

## Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$250 per person or \$500 per 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.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay coinsurance for certain services. Some services do not count toward your catastrophic protection out-of-pocket maximum and you will continue to pay copays and/or coinsurance for those services. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more specific information.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible...
<p><b>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</b></p>	
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan 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.</p> <p>Note: Drugs prescribed for your condition are covered under the <i>Prescription drug benefits</i>. (See Section 5(f))</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$15 per office visit for services performed in a doctor's office; otherwise 20% of charges</p>
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	<p>20% of charges</p>
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility (including prescription drugs billed by the facility)</li> <li>• Services in an approved alternate care setting such as partial hospitalization, residential treatment, or facility-based intensive outpatient treatment</li> </ul>	<p>20% of charges</p>
<p><i>Not covered:</i></p>	<p><i>All charges.</i></p>

*Mental health and substance abuse benefits - continued on next page*

Benefit Description	You pay After the calendar year deductible...
<b>Mental health and substance abuse benefits (cont.)</b>	
<ul style="list-style-type: none"> <li>• <i>Services we have not authorized or approved</i></li> </ul> <p><i>Note: 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.</i></p>	<p><i>All charges.</i></p>
<p>Preauthorization</p>	<p>You must follow your treatment plan and all of our network authorization processes in order for us to cover your care. These include:</p> <ul style="list-style-type: none"> <li>• You must use a Plan provider and show them your ID card.</li> <li>• Your Plan provider will contact PHP for all services including precertification.</li> <li>• We list mental health and substance abuse Plan providers in the Provider Directory that we update periodically. This list is also in our Web site.</li> </ul> <p>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 Web site at <a href="http://www.phpni.com">www.phpni.com</a>.</p>

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## Section 5(f) Prescription drug benefits

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### 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 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.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 catastrophic protection out-of-pocket maximum does not apply to prescription drugs. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.

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

- **Who can write your prescription.** Any physician with a valid Drug Enforcement Agency number can write your prescription.
- **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 Web site at [www.phpni.com](http://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 \$1,000 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
<b>Covered medications and supplies</b>	
<p>We cover the following medications and supplies prescribed by a Plan doctor and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> <li>• Diabetic supplies</li> <li>• Drugs and medicines that by Federal law of the United States require a doctor's prescription for their purchase</li> <li>• Insulin (with a copayment applied to each vial)</li> <li>• Disposable needles and syringes needed to inject prescribed diabetes medications</li> <li>• Contraceptive drugs and devices</li> <li>• Supplemental Feedings for metabolic disorders such as: Phenylketonuria (PKU) and Tyrosanemia</li> </ul> <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable contraceptive drugs are covered under Section 5(a).</p>	<p>\$10 generic per prescription unit</p> <p>\$20 brand name formulary per prescription unit</p> <p>\$40 brand name non-formulary per prescription unit</p>
<p>Mail-order:</p> <p>Up to a 90-day supply of <b>certain</b> prescription maintenance drugs that you use on an extended basis.</p>	<p>\$20 generic per prescription unit</p> <p>\$50 brand name formulary per prescription unit</p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay
<b>Covered medications and supplies (cont.)</b>	
<p>Note: Nail fungus drugs, infertility drugs, and sexual dysfunction drugs are not available through the mail-order program.</p>	<p>\$20 generic per prescription unit</p> <p>\$50 brand name formulary per prescription unit</p> <p>\$120 brand name non-formulary per prescription unit</p>
<p>Specialty pharmacy medications such as but not limited to: Acthar HP Gel; Amevive; Aranesp; Avonex; Betaseron; Copaxone; Copegus (oral); Enbrel; Epogen; Forteo; Genotropin; Gleevac (oral); Humatrope; Humira; Increlex; Infergen; Intron-A; Kineret; Leukine; Lovenox; Neulasta; Neupogen; Norditropin; Novantrone; Nutropin AQ; Orenicia; Pegasys; Peg-Intron; Procrit; Protropin; Raptiva; Rebetro (oral generics); Rebiff; Remicade; Rituxan; Roferon-A; Saizen; Sandostatin; Serostim; Temodar (oral); Tysabri; Xeloda (oral); and Xolair.</p> <p>We periodically review and update the list of specialty medications. Please contact us to verify if your drug is on the specialty drug list.</p> <p>Specialty drugs have specific characteristics, such as but not limited to:</p> <ul style="list-style-type: none"> <li>• generally injectable;</li> <li>• high in cost;</li> <li>• special handling requirements; and/or</li> <li>• require special training in order to use.</li> </ul> <p>Note: We must authorize all specialty pharmacy medications in advance and you must purchase them from our participating specialty drug vendor.</p>	<p>25% of eligible charges up to \$250 per drug for up to a 30-day supply unless limited by drug manufacturer's packaging per prescription, order, or refill.</p> <p>Note: Your annual out-of-pocket maximum for specialty pharmacy medications is \$2,500 per person per calendar year.</p>
<p>Norplant and other internally implanted time-released medications</p> <p>Note: There will be no refund of any portion of these charges if the implanted time-released medication is removed before the end of its expected life.</p> <p>Note: Maximum benefit payable for Norplant and other internally implanted time-released medications is one implant per person every five calendar years.</p>	<p>40% of charges per implantation</p>
<p>All Infertility drugs</p> <p>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.</p> <p>Note: Maximum benefit payable for infertility drugs is \$1,500 per person per calendar year.</p> <p>Note: We cover certain infertility services under the <i>Infertility services benefit</i>. (See Section 5(a))</p>	<p>40% of charges</p>
<p>Sexual dysfunction prescription drugs</p> <p>Note: We limit these prescription drugs to a 6-dose supply per month.</p> <p>Note: Maximum benefit payable for sexual dysfunction drugs is \$1,000 per person per calendar year.</p>	<p>40% of charges</p>

Benefit Description	You pay
<b>Covered medications and supplies (cont.)</b>	
<p>Note: We cover certain durable medical equipment to treat sexual dysfunction. (See Section 5(a) <i>Durable medical equipment</i>)</p>	40% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Smoking cessation drugs and medication, including nicotine patches</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a Plan doctor prescribes or administers them, except for supplemental feedings for metabolic disorders</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs and products used for weight loss or appetite suppression unless prescribed for narcolepsy or hyperkinesias</i></li> </ul>	<i>All charges.</i>

## Section 5(g) Special features

Feature	Description
<b>Services for deaf and hearing impaired</b>	A Telecommunication Device for the Deaf (TDD) is available for the deaf and hearing impaired by calling PHP at 260/459-2600.
<b>High risk pregnancies</b>	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.
<b>Centers of excellence</b>	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.
<b>Travel benefit/services overseas</b>	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(h) 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.
- The calendar year deductible is: \$250 per person or \$500 per 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.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay coinsurance for certain services. Some services do not count toward your catastrophic protection out-of-pocket maximum and you will continue to pay copays and/or coinsurance for those services. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more specific information.

Benefit Description	You Pay
<b>Accidental injury benefit</b>	
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.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Injury to the teeth caused by eating, chewing, or biting.</i></li> <li>• <i>Any charges for services that are beyond the first 24 hours of accidental injury.</i></li> <li>• <i>Temporary prosthetics including but not limited to:</i> <ul style="list-style-type: none"> <li>- <i>partial or full dentures or bridges or</i></li> <li>- <i>replacement prosthesis</i></li> <li>- <i>manipulative, corrective or cosmetic adjustments of the teeth</i></li> <li>- <i>orthodontia services</i></li> </ul> </li> <li>• <i>Any other dental services</i></li> </ul>	<i>All charges.</i>
<b>Dental benefits</b>	
We have no other dental benefits.	<i>All charges.</i>

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## Non-FEHB benefits available to Plan members

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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.

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

- **Smoking Cessation** - a reimbursement program for members who utilize any type of therapy for smoking cessation in order to successfully stop smoking for a duration of not less than one year after therapy has stopped. Therapies include: nicotine patches, nicotine gum, nicotine inhalers and/or classes. 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 Web site at [www.phpni.com](http://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 Web site at [www.phpni.com](http://www.phpni.com).

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

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## Section 6 General exclusions – things we don't cover

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

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; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7 Filing a claim for covered services

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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 HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or through our Web site at [www.phpni.com](http://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 HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name 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 payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

### **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 within 12 months after the date of service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

### **When we need more information**

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

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## Section 8 The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"><li>a) Write to us within 6 months from the date of our decision; and</li><li>b) Send your request to us at: Physicians Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804-4163; and</li><li>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>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.</li></ul>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"><li>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>b) Write to you and maintain our denial - go to step 4; or</li><li>c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ul>
<b>3</b>	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>• 90 days after the date of our letter upholding our initial decision; or</li><li>• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or</li><li>• 120 days after we asked for additional information.</li></ul> <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>• Copies of all letters you sent to us about the claim;</li><li>• Copies of all letters we sent to you about the claim; and</li><li>• Your daytime phone number and the best time to call.</li></ul> <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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.

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

## 5

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

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

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

You may not sue 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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or through our Web site at [www.phpni.com](http://www.phpni.com) and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

### 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; and
- 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 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. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

### • 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 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 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.

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 payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or see our Web site at [www.phpni.com](http://www.phpni.com).

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

- **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) or at [www.medicare.gov](http://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), but 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 payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, 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 payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
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 payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
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.

**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 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.

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## Section 10 Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services (for example, office visits). See page 12.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Non-health related services such as assistance with activities of daily living or health related services that: <ul style="list-style-type: none"><li>• Do not seek to cure;</li><li>• Are provided when the medical condition of the Member is not changing;</li><li>• Do not require administration by skilled, licensed medical personnel because a non-professionally qualified person can be trained to perform them.</li><li>• Custodial care that lasts 90 days or more is sometimes known as long-term care.</li></ul>
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
<b>Experimental or investigational service</b>	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.
<b>Group health coverage</b>	The contract between PHP and the Office of Personnel Management for FEHB employees.
<b>Medical necessity</b>	Health Services that are determined by PHP to be <i>all</i> of the following: <ul style="list-style-type: none"><li>• medically appropriate and necessary to meet the Member's basic health needs;</li><li>• 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;</li><li>• consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;</li><li>• 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;</li><li>• required for reasons other than the comfort or convenience of the member or his or her doctor;</li><li>• of a demonstrated medical value in treating the condition of the Member; and</li><li>• consistent with patterns of care found in established managed care environments for treatment of the particular health condition.</li></ul>
<b>Morbid obesity</b>	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.

**Out of pocket maximum** The maximum amount of coinsurance that a member must pay each calendar year before we will provide 100% coverage for certain eligible services. Some services do not accumulate to the out-of-pocket maximum (office visit copays, durable medical equipment, prescription drug copays, etc.) and you will continue to pay copayments or coinsurance for these services. See page 12.

**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.

**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.

**Us/We** Us and We refer to Physicians Health Plan.

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

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## Section 11 FEHB Facts

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### 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.

### Where you can get information about enrolling in the FEHB Program

See [www.opm.gov/insure/health](http://www.opm.gov/insure/health) for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who 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 Employees Health Benefits Plans*, 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;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

### 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 unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 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 when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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.

### 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 2007 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 2006 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.

**When you retire**

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

**When you lose benefits**

**When FEHB coverage ends**

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

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

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

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

## Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans 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 Web site, [www.opm.gov/insure](http://www.opm.gov/insure).

## Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.

## Converting to individual coverage

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

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

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

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

## Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at [www.opm.gov/insure/health](http://www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

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## Section 12 Three Federal Programs complement FEHB benefits

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### Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis.

### The Federal Long Term Care Insurance Program – *FLTCIP*

#### It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

### The Federal Flexible Spending Account Program – *FSAFEDS*

#### What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **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 dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** - Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

**What expenses can I pay with an FSAFEDS account?**

For the HCFSA - Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit [www.FSAFEDS.com](http://www.FSAFEDS.com)

**Who is eligible to enroll?**

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit [www.FSAFEDS.com](http://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.

**When can I enroll?**

If you wish to participate, you must make an election to enroll each year by visiting [www.FSAFEDS.com](http://www.FSAFEDS.com) or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

**Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.**

**Who is SHPS?**

SHPS is the Third-Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

**Who is BENEFEDS?**

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

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

**Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

**Dental Insurance**

Dental plans will provide a comprehensive range of services, including the following:

- 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 a 24-month waiting period.

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**Vision Insurance**

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**What plans are available?**

You can find a comparison of the plans available and their premiums on the OPM website at [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision). This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

**Premiums**

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision).

**Who is eligible to enroll?**

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

**Enrollment types available**

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

**Which family members are eligible to enroll?**

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

**When can I enroll?**

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season - November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

**How do I enroll?**

You enroll on the Internet at [www.BENEFEDS.com](http://www.BENEFEDS.com). BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888-FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

**When will coverage be effective?**

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 - December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

**How does this coverage work with my FEHB plan's dental or vision coverage?**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

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.

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## Summary of benefits for Physicians Health Plan of Northern Indiana - 2007

- **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 \$250 per person and \$500 per family.

Benefits	You pay	You pay
<b>Medical services provided by physicians:</b>		
• Office visits	\$15 per visit	15
• Diagnostic laboratory tests and other treatment services	20% of charges*	15
<b>Services provided by a hospital:</b>		
• Inpatient or Outpatient	20% of charges*	29
<b>Emergency benefits:</b>		
• In-area or Out-of-Area	\$15 per doctor's office visit; \$30 per urgent care center visit; or \$75 per hospital emergency room visit	34
<b>Mental health and substance abuse treatment:</b>	Regular cost sharing*	34
<b>Prescription drugs:</b>		
• Up to a 30 day supply	\$10 generic/\$20 brand name formulary/ \$40 brand name non-formulary per prescription unit or refill	37-40
<b>Mail-order drugs:</b>		
• Up to a 90 day supply of medication	\$20 generic/\$50 brand name formulary/ \$120 brand name non-formulary per prescription unit or refill	38
<b>Specialty pharmacy drugs:</b>	25% coinsurance up to \$250 maximum per prescription. Specialty pharmacy drugs will be covered at 100% after you pay \$2,500 out-of-pocket per person per calendar year	39
<b>Dental care:</b>		
• No benefit	All Charges	42
<b>Vision care:</b>		
• Limited to one annual eye refraction for members 18 and over	\$20 copay	20

<p><b>Protection against catastrophic costs:</b> Medical - \$2,500/Self Only or \$5,000 Self and Family per year</p>	<p>Nothing for certain services as specified in the brochure</p>	<p>12</p>
<p><b>Protection against specialty pharmacy drugs:</b> You have a separate responsibility of \$2,500 out-of-pocket maximum per person per calendar year</p>	<p>Nothing for continued specialty pharmacy benefits for the remainder of the calendar year</p>	<p>12</p>

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## 2007 Rate Information for Physicians Health Plan of Northern Indiana

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

**Postal rates** apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
<b>High Option Self Only</b>	DQ1	141.92	50.65	307.49	109.75	167.54	25.03
<b>High Option Self and Family</b>	DQ2	321.89	108.83	697.43	235.80	380.01	50.71