Physicians Health Plan (formerly Physicians Health Plan of Mid-Michigan)

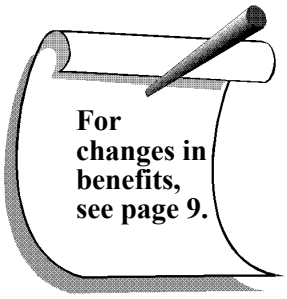
www.phpmm.org

2012

A Health Maintenance Organization

Serving the Michigan counties of Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Isabella, Jackson, Montcalm, and Shiawassee, and partial counties of Lenawee, Saginaw and Washtenaw.

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



This Plan has 2012 Excellent accreditation from the NCQA. See the 2012 Guide for more information on accreditation.

Enrollment Codes for this Plan:

9U4 Self Only

9U5 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Physicians Health Plan About Our Prescription Drug Coverage

OPM has determined that the [FEHB Plan'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 your FEHB plan will coordinate benefits with Medicare.

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

Please Be Advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly 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 (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Physicians Health Plan (PHP) under our contract (CS 2915) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for PHPMM's administrative offices is:

Physicians Health Plan, 1400 E Michigan Avenue, Lansing, Michigan 48912

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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee 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 or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, or authorized health benefit 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.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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 517/364-8567 or 866-539-3342 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)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of materioal fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1.Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines 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 the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

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 reaction to anesthesia, and any medications you are taking.

Patient Safety Links

www.ahrq.gov/consumer. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Physicians Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

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

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. 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 or go online to www.phpmm.org.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the Copayments, Coinsurance, and Deductibles described in this brochure. When you receive emergency or urgent care services from non-Network 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.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at PHP Customer Service at 517-364-8567 or 866-539-3342. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our Standard Option

This Plan offers a Standard Option. The benefit package is described in Section 5.

Under the Standard Option, the Calendar Year Deductible is $500 per person, or $1,000 per family

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your Primary Care Physician or by another participating provider in the Network.

We have Point of Service (POS) benefits

Our HMO offers Point-of-Serice (POS) benefits. This means you can receive covered services from a non-participating provider. However, non-network Benefits may have higher out-of-pocket costs than our non-network Benefits.

How we pay providers

We contract with individual Physicians, medical groups, and Hospitals to provide the Benefits in this brochure. These Network providers accept a negotiated payment from us, and you will only be responsible for your Copayments 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, providers, and facilities. OPM's FEHB Web site (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.

PHP is a non-profit managed care organization serving mid-Michigan for over 30 years. PHP believes that its members are an important part of our health team and that they have a responsibility for their own health.

If you want more information about us, call 517-364-8400, or write to Physicians Health Plan, 1400 E. Michigan Avenue, Lansing, MI 48912. You may also contact us by fax at 517-364-8460 or visit our Web site at www.phpmm.org.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our Service Area is:

Michigan (select counties) - Clinton, Eaton, Gratiot, Hillsdale, Ingham, Ionia, Isabella, Jackson, Montcalm, and Shiawassee counties, and partial counties - Lenawee, Saginaw and Washtenaw.

Ordinarily, you should get your care from providers who contract with us. If you receive care outside our service area, you will be responsible for the Copayments or Coinsurance listed under the non-Network Benefits section of the charts beginning on page 20, unless it is an emergent or urgent condition, as defined in this Plan. Some services require prior authorization from us.

If you or a covered family member move outside of our Service Area, you must 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. Contact your employing or retirement office for more information.

Section 2. How we change for 2012

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

Program Wide Changes

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family for the Standard Option. See page 90.
- To comply with the recommended coverage for transplants, the plan will add the following services under the Organ/Tissue Transplant benefit:
  - Waldenstrom's macroglobulinemia;
  - Childhood rhadomyosarcoma;
  - Advanced Childhood kidney cancers;
  - Mantle Cell (non-Hodgkin lymphoma);
  - Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) and
  - Myelodysplasia/Myelodysplastic Syndromes
- PHP's service are has expanded to include Hillsdale and Jackson counties, as well as partial counties of Lenawee and Washtenaw.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 517-364-8567 or 866-539-3342 or write to us at Physicians Health Plan, 1400 E. Michigan Avenue, Lansing, MI 48912. You may also request replacement cards through our Web site - www.phpmm.org.

Where you get covered care

You get care from "Network providers" and "Network facilities." You will only pay Copayments, Deductibles, and/or Coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use out Open Accee program you can receive covered services from a patrticipating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **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

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a pediatrician, internist, obstetrician, gynecologist, or in family or general practice. Your primary care physician will provide most of your health care, or assist you in making an appointment to see a specialist.

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

- **Specialty care**

You do not need a referral to see a Plan specialist for needed care. However, you are encouraged to return to your Primary Care Physician after the consultation so that your Primary Care Physician is aware of your condition and can assist in your care.

- If you are seeing a Plan specialist and your specialist leaves the Plan, call your primary care provider or PHP at (517) 364-8567 or 866-539-3342 and we will help you find another specialist.
- If you have a chronic and disabling condition and lose access to your specialist because we: 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.
  - Terminate our contract with your specialist for other than cause,
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan, or
  - Reduce our service area and you enroll in another FEHB Plan;

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. Contact Customer Service at 517-364-8567 or 866-539-3342 so that we are aware of your situation.

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 517-364-8567 or 866-539-3342. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

- **Inpatient hospital admission**

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

- **Other services**

For certain services, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Your must obtain pre-authorization for:

- Transplants
- Ambulance services (non-emergency)
- Dental anesthesia (pediatric/adult)
- Dental services (accident)
- Durable medical equipment over $500
- Genetic testing
- Home health care
- Hospice care
- Hospital inpatient stay (including extended maternity stay and emergency admissions)
- Prosthetic devices over $1,000
- Reconstructive procedures
- Specialty pharmaceuticals
- Speech therapy
- Skilled nursing facility/inpatient rehabiliation facility
- Behavioral health services

How to request pre-authorization for an admission or Other services

First, your physician, your hospital, or your representative, must call us at 517-364-8567 or 866-539-3342 before admission or services requiring prior authorization are rendered:

Next, provide the following information:

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

- **Non-urgent care claims**

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

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

- **Emergency inpatient admission**

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

- **Maternity care**

We must be notified as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described on page 22.

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

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

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

Covered Health Services	Non-Authorization Impact on Benefits
Ambulance services – non-emergency	No Benefits will be paid
Dental anesthesia – pediatric/adult	No Benefits will be paid
Dental services – accident	Benefits will be reduced to 50% of eligible expenses
Durable Medical Equipment over $500	No Benefits will be paid
Genetic testing	No Benefits will be paid
Home health care	Benefits will be reduced to 50% of Eligible Expenses
Hospice care	Benefits will be reduced to 50% of Eligible Expenses
Hospital Inpatient Stay (including extended maternity stay and Emergency admissions)	Benefits will be reduced to 50% of Eligible Expenses
Prosthetic devices over $1,000	No Benefits will be paid
Reconstructive procedures	Benefits will be reduced to 50% of Eligible Expenses
Specialty Pharmaceuticals Note: This list is subject to change.	No Benefits will be paid if certain criteria are not met
Speech therapy	No Benefits will be paid
Skilled Nursing Facility/Inpatient Rehabilitation Facility	Benefits will be reduced to 50% of Eligible Expenses
Behavioral Health Services – inpatient stay/ intermediate care	Benefits will be reduced to 50% of Eligible Expenses
Behavioral Health Services - residential treatment program for substance use disorders	Benefits will be reduced to 50% of Eligible Expenses
Behavioral Health Services - outpatient care NOTE: certain services such as intensive outpatient therapy, ECT, extended psychotherapy, and neuro/cognitive/psycho-diagnostic testing require authorization. Please call PHP or the Behavioral Health Designee for more information.	No benefits will be paid
Transplant services	No benefits will be paid

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your cost for covered services

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

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 $20 per office visit for the Standard Option.

Cost-Sharing

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

Deductible

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

- The Network Calendar Year Deductible is $500 per person under the Standard Option. Under a family enrollment, the Deductible is considered satisfied and Benefits are payable for all family members when the combined covered expenses applied to the Calendar Year Deductible for family members reach $1,000 under the Standard Option.
- The Out-of-Network Calendar Year Deductible is $1,000 per person under the Standard Option. Under a family enrollment, the Deductible is considered satisfied and benefits are payable for all family memebers when the combined covered expenses applied to the Calendar Year Deductible for family members reach $2,000 under the Standard Option.

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

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the Deductible of your old option to the Deductible of your new option.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you must pay for your care. Coinsurance doesn't begin until you meet your annual Deductible.

Example - In our Plan you pay 50% of Eligible Expenses for infertility services.

Differences between Eligible Expenses and the bill

For Network Benefits, you are not responsible for an difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills and the amount we will pay for Eligible Expenses.

Your Catastrophic Protection (Out-of-Pocket Maximum)

After your copayments and coinsurance totals $1,500 per person or $3,000 per family enrollment in any Calendar Year for Network Benefits or $3,000 per person or $6,000 per family for Non-Network Benefits, you do not have to pay any more for covered services except for Copayments.

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

- Any charges for non-Covered Health Services
- Charges that exceed Eligible Expenses
- The amount of any reduced Benefits if you don't obtan required authorization from us as described in Section 3
- The Annual Deductible

Carryover

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

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

When Government facilities bill us

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

Standard Option Benefits

See page 9 for how our Benefits changed this year. On page 86, you'll find a benefits summary.

Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. The Benefit package is described in Section 5. Make sure that you review the Benefits carefully.

Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also, read the general exclusions in Section 6, they apply to the Benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about Standard Option Benefits, contact us at 517-364-8567 or 1-866-539-3342 or at our Web site at www.phpmm.org.

Standard Option

- Deductible: $500 per person/$1,000 per family when you use Network providers. $1,000 per person/$2,000 per family when you use non-Network providers
- Office Visits - you pay $20 when you see a Network provider
- Prescription Drugs - Retail: You pay a $15 Copayment for Tier-1 drugs (mostly generic), a $25 Copayment for Tier-2 drugs (mostly brand-name), and a $50 Copayment for Tier-3 drugs (non-preferred covered drugs)
- Vision Services - Exam - you pay $20 when you see a Network provider; Lenses and frames to a maximum of $90 per person per Calendar Year; or contact lenses to a maximum of $130 per person per Calendar Year.

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.
- Network physicians should provide your care for you to pay the lowest Copayments or Coinsurance.
- The Standard Option Network Calendar Year Deductible is: $500 per person ($1,000 per family). The Standard Option non-Network Calendar Year deductible is $1,000 per person ($2,000 per family). The Calendar Year Deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**Standard Option**
Professional services of a Physician in a Physician's office	Network - $20 per office visit (no deductible) Non-Network - all charges
Not Covered: • *Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:* - *has not been actively involved in your medical care prior to ordering the service, or* - *is not actively involved in your medical care after the service is received.*	All charges
Lab, X-ray and other diagnostic tests	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Prenatal ultrasound	Network - Nothing (no deductible) Non-Network - 30% Coinsurance after Deductible
Tests, such as: • CAT Scans/MRI/MRA • PET Scans • Nuclear Medicine	Network - Nothing (No Deductible) Non-Network - 30% Coinsurance after Deductible

Benefit Description	You pay
Preventive Care, Adult	**Standard Option**
Benefits for Covered Health Services that are designated to keep you in good health and to prevent unnecessary Injury, Sickness or disability in accordance with our current "Preventive Guidelines." These guidelines include the following as may be appropriate based on your age and/or sex: Annual routine physical which includes routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 • Colonoscopy screening – every ten years starting at age 50 • Prostate Specific Antigen (PSA) test - one annually for men age 40 and older • Pap test • Immunizations • Hearing exam • Mammogram - One badeline breast cancer screening mammography for women over age 35 and under age 40 - One breast cancer screening mammogram per Calendar Year for women age 40 and older	Network - Nothing (No Deductible) Non-Network - All charges
Not covered: *Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for the purposes of medical research; required to obtain or maintain a license of any type.*	All charges
Preventive Care, Children	**Standard Option**
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction	Network - Nothing (No Deductible) Non-Network - All charges

Preventive Care, Children - continued on next page

Benefit Description	You pay
Preventive Care, Children (cont.)	**Standard Option**
- Examinations done on the day of immunizations (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics	Network - Nothing (No Deductible) Non-Network - All charges
Maternity care	**Standard Option**
Pre- & Postnatal Care	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Delivery	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Note: Here are some things to keep in mind: • You do not need to pre-authorize your normal delivery. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if Medically Necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant as a member. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and Injury. *Authorization Requirements* If you use non-Network Benefits, you or your provider must obtain authorization from us as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn baby will be more than the time frames described above. If this extended stay is not authorized by us, your non-Network Benefits will be reduced to 50% of Eligible Expenses.	
Well-baby and well-child care	Network - $20 Copayment (No Deductible) Non-Network - All charges
Not covered: • *Services and supplies for home births* • *Free-standing birthing centers*	All charges

Benefit Description	You pay
Family planning	**Standard Option**
A range of voluntary family planning services:	
• Surgical Sterilization	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
• Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms	Network - $20 office visit (No Deductible) Non-Network - All charges
Infertility services	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) when provided by or under the direction of a Network Physician. Fertility drugs - we cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	Network - 50% Coinsurance, after Deductible Non-Network - All charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization.* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT).* • *Services and supplies related to ART procedures.* • *Cost of donor sperm and related costs including collection and preparation.* • *Cost of donor egg and related costs including collection and preparation.* • *The reversal of surgical sterilization.*	All charges
Allergy care	**Standard Option**
• Testing and treatment • Allergy injections • Allergy serum Note: If seen by a Physician, the office visit Copayment will apply.	Network - Nothing (No Deductible) Non-Network - All charges

Benefit Description	You pay
Treatment therapies	**Standard Option**
• Chemotherapy and radiation therapy - Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 36. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth Hormone Therapy (GHT) - Note: Growth Hormone Therapy is covered under the prescription drug benefits (see page 50). We only cover GHT when we preauthorize the treatment. We will ask you to submit infomration that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services on page 11.	Network - Hospital - Nothing (No Deductible); Physician's office - $20 Copayment (No Deductible) Non-Network - Hospital - 30% Coinsurance (after Deductible); Physician's office - All charges
Physical, speech, and occupational therapies	**Standard Option**
Short-term outpatient rehabilitation services for: • Physical therapy • Occupational therapy • Speech therapy (subject to specific restrictions and exclusions) • Pulmonary rehabilitation therapy • Phase I and II cardiac rehabilitation therapy Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Rehabilitation services must be performed at a Hospital, Skilled Nursing Facility, Alternate Facility, or through a Home Health Agency. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Benefits for any combination (Network and/or Non-Network) of physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation therapy are limited to 60 visits per calendar year. Any combination of Network and Non-Network Benefits for Phase I and II cardiac rehabilitation therapy is limited to 36 visits per calendar year.	Network - $20 per office visit or outpatient visit (No Deductible) Non-Network - 30% Coinsurance after Deductible Nothing per visit during covered Inpatient admission
Not covered:	All charges

Physical, speech, and occupational therapies - continued on next page

Benefit Description	You pay
Physical, speech, and occupational therapies (cont.)	**Standard Option**
• *Gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment.* • *Inpatient or Outpatient recreational Therapy* • *Long-Term Rehabilitative Therapy*	All charges
Hearing services (testing, treatment, and supplies)	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening peformed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	Network - Nothing (No Deductible) Non-Network - All charges
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**
Benefits for vision care services and materials obtained from a vision care provider. Benefits are as follows: • Annual eye exam	Network - $20 per office visit (No Deductible) Non-Network - All charges
Not covered: • *Non-corrective eyeglasses or contact lenses* • *Vision therapy or sub-normal vision aids* • *Replacement of lost or broken lenses or frames, if benefits applicable to the replacement were previously provided during the Calendar Year* • *Cost of frames or contact lenses which exceed the maximum Benefits* • *Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery*	All charges

Benefit Description	You pay
Foot care	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	Network - $20 per office visit (No Deductible) Non-Network - All charges
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	All charges
Orthopedic and prosthetic devices	**Standard Option**
Prosthetics are covered for the basic item and any special features that are Medically Necessary and pre-authorized by PHP, (pre-authorization is required for those prosthetics over $1,000 only) that replace a body part including: • Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids and hearing aid services are available once every 36 months. Benefits are limited to: - $880 for a monaural hearing aid - $1,600 for binaural hearing aids - Benefits include audiometric examinations and hearing aid evaluations through a network hearing aid provider to determine atual hearing acuity and the specific type or band of hearing aid needed. - Benefits also include the purchase and fitting of either a monaural or binaural hearing aid(s) (which must be of the in-the-ear, behind-the-ear, or on-the-body type). This includes one hearing aid check following the fitting. - Benefits are provided for CROS, BICROS, Canal and eyeglass type hearing aids and other special hearing aids, not to exceed the Benefits we would have provided for a unilateral hearing aid, as described above. - Benefits are not provided for bone anchored hearing aids (BAHA) and cochlear implant devices, however surgery to implant the devices may be covered. However, the surgery to insert internal devices may be covered. See Section 5(b) for coverage, if applicable.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	**Standard Option**
• Note: For information on the professional charges for the surgery to insert an implant, see Section 5 (b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. If more than one prosthetic device can meet your functional needs, Benefits are available for only the prosthetic device that meets the minimum specifications for your needs. If you choose to purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost. The prosthetic device must be ordered or provided by, or under the supervision of a Physician. Benefits are not provided for repair, replacement, or duplicates nor are benefits provided for health services related to the repair or replacement, except when necessitated due to a change in your medical condition, a change in body size due to growth, or to improve physical function.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stickings, support hose, and other supportive devices* • *Prosthetic replacements provided less than three years after the last one we covered* • *All other hearing aids, except as specified above* • *Hearing aid accessories (such as ear molds)* • *Replacement of hearing aids that are lost or broken* • *Other hearing aid replacement parts and repairs* • *Any device that is fully implanted into the body except for breast prostheses.*	All charges
Durable Medical Equipment (DME)	**Standard Option**
We cover rental or purchase of Durable Medical Equipment, which is: • Ordered or provided by a Physician for outpatient use • Used for medical purposes • Not consumable or disposable • Of use to a person only in the presence of a disease or physical disability	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You pay
Durable Medical Equipment (DME) (cont.)	**Standard Option**
If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are only for the equipment that meets the minimum specifications for your needs. If you choose to purchase Durable Medical Equipment that exceeds these minimum specifications, we will only pay the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost. Examples of covered items include: • Oxygen and rental of the equipment to administer oxygen • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure • Dialysis equipment • Hospital beds • Wheelchairs (Benefits for a power operated wheelchair may be provided if - you are capable of safely operating the controls, have adequate upper body stability to ride safely, and are able to transfer in and out of the wheelchair) • Crutches • Walkers • Audible prescription reading device • Speech generating device • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize a body part affected by Injury, Sickness, or Congenital Anomaly are considered Durable Medical Equipment and are a Covered Health Servic • Delivery pumps for tube feedings (including tubing and connectors) • Bi-pap and C-pap machines (including tubing, connectors, and masks) • Blood glucose monitors • Insulin pumps Note: You or your provider must call us at 517-364-8567 or 866-539-3342 for authorization if the Durable Medical Equipment's cost exceeds $500 (either purchase price or cumulative rental of a single item). If you or your provider does not obtain authorization from us, Non-Network Benefits will not be paid.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You pay
Durable Medical Equipment (DME) (cont.)	**Standard Option**
If we determine that purchase, repair or replacement is necessary, we provide Benefits for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three Calendar Years. Benefits are not available for duplicate Durable Medical Equipment items. Benefits are provided for replacement only when necessitated due to a change in your medical condition or a change in body size, or to improve physical function. Tubing, connectors, and masks (as a initial purchase and replacement) are limited to four of each type per Calendar Year. We will decide if the equipment should be purchased or rented. We will also decide if the equipment should be repaired or replaced.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Not covered: • *Dental braces* • *Personal comfort items* • *Devices used specifically as safety items and/or to affect performance in sports-related activities* • *Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:* - *Elastic, surgical and compression stockings (for example, TEDs and JOBST stockings)* - *Ace bandages* - *Gauze and dressings* - *Syringes, except as provided as diabetes supplies* • *Shoes and shoe orthotics* • *Cranial helmets* • *Power operated wheelchairs, if you:* - *Can walk, or* - *Can use a manual wheelchair, or* - *Only need it for leisure activities, or* - *Would not need it for use in your home* • *All bath aids, for example, shower chairs and safety rails* • *Toiler seat risers* • *Grabbers* • *Stair lifts* • *Ramps* • *Diapers* • *Home modifications* • *Wheelchair lifts* • *Life chairs*	All charges

Durable Medical Equipment (DME) - continued on next page

Benefit Description	You pay
Durable Medical Equipment (DME) (cont.)	**Standard Option**
• *Commodes* • *Standing systems, stationary and mobile* • *Automobile modifications and adaptive devices,(for example, hand grips, hand controls and special foot pedals)* • *Mobility carts and power-operated vehicles, (for example, scooters, motorized carts, and electric scooters)* • *Car seats and/or safety seats* • *Strollers* • *Shoe lifts* • *Temper-pedic and all other mattresses* • *Air conditioners. Air purifiers and filters or air cleaning devices. Dehumidifiers and humidifiers* • *Batteries and battery chargers* • *Hot tubs and whirlpools. Tanning beds, lamps and services. Light bulbs and short and long wave UV light units to be used in the home* • *Oral appliances for snoring*	All charges
Home health services	**Standard Option**
• Home health care ordered by a Physician and provided or supervised by a registered nurse (R.N.), in your home. • Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. • Services include oxygen therapy, intravenous therapy and medications. • Skilled care is skilled nursing, skilled teaching, skilled rehabilitation, and home infusion services, when all of the following are true: - it must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient - it is ordered by a physician - it is not delivered for the purpose of assisting with the activities of daily living, including, but not limited to dressing, feeding, bathing or transferring from bed to a chair - it requires clinical training in order to be delivered safely and effectively, and - it is not custodial care.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**Standard Option**
Our determination is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Benefits are limited to 60 visits per Calendar Year in any combination of Network and Non-Network Benefits. **Authorization Requirements** You or your provider must obtain authorization from us before receiving services. If authorization is not obtained, Non-Network Benefits will be reduced to 50% of Eligible Expenses.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial Care* • *Domiciliary care* • *Private duty nursing* • *Respite care* • *Rest cures*	All charges
Chiropractic	**Standard Option**
• Chiropractic analysis, diagnosis and adjustment of the spinal condition requiring chiropractic services. • Adjustment of any bones and tissues related to the spinal condition requiring chiropractic services. • Rehabilitative exercise related to spinal subluxations or spinal misalignments. • X-rays of the spine. Benefits are limited to a maximum of 18 visits per Calendar Year.	Network - $20 per visit (No Deductible) Non-Network - All charges
Not covered: • *Chiropractic services that exceed the visit limits* • *Any chiropractic service not related to the spine* • *Laboratory services* • *Consultations* • *Rehabilitative exercise not related to spinal subluxations or spinal misalignments* • *Fracture care* • *Nutritional advice*	All charges

Chiropractic - continued on next page

Benefit Description	You pay
Chiropractic (cont.)	**Standard Option**
• *Inpatient hospitalization*	All charges
Alternative treatments	**Standard Option**
PHPMM does not pay for alternative treatments - including, but not limited to, the following: • *Acupressure and acupuncture* • *Aroma therapy* • *Hypnotism* • *Massage therapy* • *Rolfing* • *Herbal or vitamin therapies* • *Hair testing and analysis* • *Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM), a component of the National Institute of Health.*	All charges
Educational classes and programs	**Standard Option**
Coverage is provided for: • Tobacco cessation services include: - Individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Preferred tobacco cessation products must be prescribed by a Physician and obtained from a Network retail pharmacy, even if the product is available as an over-the-counter product. - Clinical assessment of readiness to change - Specifically credentialed providers - Preferred tobacco cessation products must be prescribed by a Physician and obtained from a Network retail pharmacy, even if the product is available as an over-the-counter product. - Benefits are limited to a maximum of two quit attempts and three months of nicotine replacement therapy per calendar year. - You must notify us to participate in this program, and you must participate in the program to receive the above Benefits. You must be at least 18 years old to participate in the program.	Network - Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Non-Network - All charges
• Diabetes self management • Childhood obesity education	Network - $20 per office visit Non-Network - All charges

Benefit Description	You pay
Nutritional counseling services	**Standard Option**
Nutritional counseling services: Provided by a Network Hospital-based registered dietician. Covered Health Services must be provided under the direction of a Physician. Conditions for which nutritional counseling is a Covered Health Service include, but are not limited to: • Educational purposes for Preventive Health Services • Diabetes mellitus • Coronary artery disease • Congestive heart failure • Severe obstructive airway disease • Gout • Renal failure • Phenylketonuria • Hyperlipidemias Benefits are available when nutritional counseling is provided during an individual session. Benefits are limited to three sessions of nutritional counseling per Calendar Year.	Network - $20 per office visit (No deductible) Non-Network - All charges
Not covered: • *Megavitamin and nutrition-based therapy* • *Enteral feedings. Food replacements, nutritional and electrolyte supplements. Infant formula and donor breast milk.*	*All charges*
Weight management	**Standard Option**
Benefits for Covered Health Services provided during participation in a 24-week weight management program through a Designated Facility. Benefits are limited to one weight management program during your lifetime.	Network Only - $25 per visit (No Deductible) Non-Network - All charges
Not covered: • *Nutritional supplies* • *Body fat testing* • *Educational materials not included in weight management program fees*	All 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.
- Network Physicians must provide or arrange your care.
- The Calendar Year Deductible for the Standard Option within the Network is: $500 per person ($1,000 per family). The Calendar Year Deductible applies to almost all Benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a 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 OBTAIN AUTHORIZATION FROM US FOR SOME SURGICAL PROCEDURES. Please refer to the authorization information shown in Section 3 to be sure which services require authorization and identify which surgeries require authorization.

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section.	
Surgical procedures	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information - Note: Generally, we pay for internal prostheses (devices) according to where the procedure is performed. For example, we pay Hospital benefits for an inpatient stay to insert a pacemeaker and surgical benefits for the actual insertion of the pacemaker. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Surgical treatment of morbid obesity: • Benefits for Covered Health Services, including room and board and other services and supplies provided in a Designated Facility, for the surgical treatment of morbid obesity.	Network - 10% Coinsurance up to a maximum of $1,000 per Covered Person per lifetime. This Coinsurance does not apply to the Out-of-Pocket Maximum (No Deductible) Non-Network - All charges

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**Standard Option**
• Benefits are available only if surgical treatment is ordered by the Primary Physician or the managing Network Physician and provided by a Network Physician or designated Physician in a Designated Facility, and if the Covered Person qualifies under our current Morbid Obesity Policy. Call Customer Service at 517-364-8500, if you have questions.	Network - 10% Coinsurance up to a maximum of $1,000 per Covered Person per lifetime. This Coinsurance does not apply to the Out-of-Pocket Maximum (No Deductible) Non-Network - All charges
Not covered: • *Reversal of voluntary sterilization* • *Penile implants for the treatment of impotence having a psychological origin* • *Psychosurgery*	All charges
Reconstructive surgery	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: if you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Authorization Requirements You or your provider must obtain authorization from us before you receive services. We will verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. For Non-Network Benefits, if authorization is not obtained from us, Benefits for reconstructive procedures will be reduced to 50% of Eligible Expenses.	

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**Standard Option**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	All charges
Oral and maxillofacial surgery	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics, and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.*	All charges
Organ/tissue transplants	**Standard Option**
These solid organ transplants are subject to Medical Necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea (not required to be performed at a Designated Facility) • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney	Network - Nothing (No Deductible) Non-Network - All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Liver • Lung single/bilateral • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These tandem blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - Al Amyloidosis - Multiple myeloma (denovo and treated) - Recurrent germ cell tumors (inlcuding testicular cancer)	Network - Nothing (No Deductible) Non-Network - All charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the dianoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Infantile malignant osteoporosis • Kostmann's syndrome • Leukocyte adhesions deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) • Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g. Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Marteauz-Lamy syndrome variants)	Network - 20% Coinsurance after Deductible Non-Network - All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Myelodysplasia/myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) • Amyloidosis • Breast cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple Myeloma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia • Neurobastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors Mini-transplants oerformed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) • Acute myeloid leukemia	Network - 20% Coinsurance after Deductible Non-Network - All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Hemoglobinopathy • Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) • Myelodysplasia/myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplants for: • Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurence (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) • Amyloidosis • Neurobastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care taht is medically necessary (such as doctor's visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional infromation on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Allogeneic transplants for: • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Beta Thalassemia • Early stage (indolent or non-advanced)small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Sickle Cell anemia	Network - 20% Coinsurance after Deductible Non-Network - All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast cancer • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Colon cancer • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma • Multiple sclerosis • Myeloproliferative disorders (MSDs) • Non-small cell lung cancer • Ovarian cancer • Prostate cancer • Renal cell carcinoma • Sarcomas • Sickle cell anemia Autologous Transplants for : • Advanced Childhood kidney cancers • Advanced Ewing sarcoma Breast Cancer • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Breast Cancer • Childhood rhabdomyosarcoma • Chronic myelogenous leukemia • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Epithelial Ovarian Cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple Sclerosis • Small cell lung cancer	Network - 20% Coinsurance after Deductible Non-Network - All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
• Systemic lupus erythematosus • Systemic sclerosis	Network - 20% Coinsurance after Deductible Non-Network - All charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard Option**
Authorization Requirements We cover related medical and hospital expenses of the donor when we cover the recipient. You or your Physician must obtain authorization from us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain authorization from us and if the transplantation services are not performed at a Designated Facility, no Benefits will be paid.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above.* • *Implants of artificial organs* • *Transplant services that are not performed at a Designated Facility* • *Transplants not listed as covered*	All charges
Anesthesia	**Standard Option**
Professional services provided in a – • Hospital (inpatient or outpatient) • Ambulatory Surgical Center • Skilled Nursing Facility	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Professional services provided in provider's office	Network - $20 Copayment (No Deductible) Non-Network - All charges

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

Important things you should keep in mind about these Benefits:

- Please remember that all Benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Network physicians must provide or arrange your care and you must be hospitalized in a Network facility to receive Network Benefits.
- In this Section, unlike Sections 5(a) and 5(b), the Calendar Year Deductible applies to only a few Benefits. We added “after Deductible". The Calendar Year Deductible is: $500 per person ($1,000 per family).
- Be sure to read Section 4, *Your costs for covered health services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., Physicians, etc.) are in Sections 5(a) or (b).

Note - Authorization is required:

- For elective admissions: five business days before admission.
- For non-elective admissions: within one business day or the same day of admission.
- For Emergency admissions: within one business day or the same day of admission, or as soon as reasonably possible.

If you or your provider does not obtain authorization from us, Non-Network Benefits will be reduced to 50% of Eligible Expenses.

Please refer to Section 3 to be sure which services require authorization.

Benefit Description	You pay
Inpatient Hospital	**Standard Option**
Room and board, such as • Unlimited days in semi-private, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not Medically Necessary, you pay the additional charge above the semi-private room rate.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
• Anesthetics, including nurse anesthetist services	Network - 20% Coinsurance after Deductible

Inpatient Hospital - continued on next page

Benefit Description	You pay
Inpatient Hospital (cont.)	**Standard Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a Hospital for use at home	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	All charges
Outpatient Hospital or ambulatory surgical center	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies replated to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Extended care benefits/skilled nursing care facility benefits	**Standard Option**
Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available only when skilled care is required for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-private Room (a room with two or more beds) Any combination of Network and Non-Network Benefits is limited to 100 days per Calendar Year. Our determination is based on whether or not skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. These criteria to determine skilled care may differ from criteria used by other payors.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible

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

Benefit Description	You pay
Extended care benefits/skilled nursing care facility benefits (cont.)	**Standard Option**
Authorization Requirements Please contact us immediately for more information regarding a Non-Network admission to a Skilled Nursing Facility. If you don't obtain authorization from us, Non-Network Benefits will be reduced to 50% of Elgible Expenses.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Hospice care	**Standard Option**
Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psycological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact us for more information regarding our guidelines for hospice care. Non-Network Benefits are limited to 180 days during the entire period of time you are covered under this policy. **Authorization Requirements** Please remember that you or your provider must obtain authorization from us before receiving services. If authorization is not obtained, Non-Network Benefits will be reduced to 50% of Eligible Expenses.	Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Ambulance	**Standard Option**
Emergency ambulance transportation (air or ground) by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Network Benefits are provided for non-Emergency ambulance transportation services when those services are recommended by the Primary Physician or other Network Physician and coordinated by us.	Network or Non-Network (for ground or air transportation) - 20% Coinsurance after Deductible
Not Covered: *Ambulance services that are provided by an Emergency responder that does not provide transportation.*	All charges

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these Benefits:

- Please remember that all Benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- The Standard Option's Calendar Year Deductible Network is: $500 per person ($1,000 per family). The Calendar Year Deductible does not apply to most of the Benefits in this Section. We added ("No deductible") to show when the calendar year deductible does not apply.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical Emergency?

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

What to do in case of Emergency:

Within our Service Area - If you have an injury or sudden serious illness, call your Primary Care Physician and follow the instructions you are given. If you cannot reach your Primary Care Physician and you have an Emergency condition, go directly to the nearest emergency department or call 911.

Outside our Service Area - Go directly to the nearest emergency department or call 911. As soon as possible after treatment, contact your Primary Care Physician so any necessary follow-up care can be provided or coordinated and your medical record can be updated.

Benefit Description	You pay
Emergency Services in or outside our Service Area	**Standard Option**
Emergency care:	
• at a Physician's office	Network or Non-Network - $20 per office visit (No Deductible)
• at an Urgent Care Facility	Network or Non-Network - $30 per visit (No Deductible)
• at a Hospital Emergency Department (as an Outpatient or observation stay)	Network or Non-Network - $60 per visit (No Deductible)
Note - We will waive the emergency department copayment if you are admitted for an Inpatient Stay within 24 hours for the same condition. Emergency services also cover an outpatient observation stay regardless of the length of stay for the purpose of monitoring your condition.	

Benefit Description	You pay
Ambulance	**Standard Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for more information.	Network or Non-Network (for ground or air transportation) - 20% Coinsurance after Deductible

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

You need to get Plan approval (preauthorization) for services in order to get benefits. When you receive approved services, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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 Standard Option calendar year deductible or, for facility care, the inpatient deductible applies to some of the benefits in this Section. We added "(No Deductible)" to show when a Deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process.
- We will provide medical review criteria or reasons for denials to enrollees, members or providers upon request or as otherwise required.

Benefit Description	You pay
Professional Services	**Standard Option**
Following approval, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Treatment must be provided by a licensed Physician, or other licensed behavioral health professional and received in a facility accredited by COA, AOA or JCAHO. Coverage for Behavioral Health Services is limited to the most appropriate method and level of treatment that is Medically Necessary as determined by the Behavioral Health Designee. Coverage for outpatient and day treatment services for behavioral health shall not be less than the minimum benefit established by the State of Michigan, Office of Financial and Insurance Regulation. Referrals to all behavioral health providers are determined by the Behavioral Health Designee, who is responsible for coordinating all of your care. Call 517-364-8567 or 866-539-3342 regarding Benefits for Behavioral Health Services.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	Outpatient and day treatment - Network - $20 per visit (No deductible) Non-Network - 30% Coinsurance after Deductible Inpatient - Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible

Professional Services - continued on next page

Benefit Description	You pay
Professional Services (cont.)	**Standard Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detixification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Outpatient and day treatment - Network - $20 per visit (No deductible) Non-Network - 30% Coinsurance after Deductible Inpatient - Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Diagnostics	**Standard Option**
• Outpatient diagnostics tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic test provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Outpatient and day treatment - Network - $20 per visit (No deductible) Non-Network - 30% Coinsurance after Deductible Inpatient - Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Inpatient hospital or other covered facility	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accomodations, general nursing care, meals and special diets, and other hospital services	Inpatient - Network - 20% Coinsurance after Deductible Non-Network - 30% Coinsurance after Deductible
Outpatient hospital or other covered facility	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Outpatient and day treatment - Network - $20 per visit (No Deductible) Non-Network - 30% Coinsurance
Authorization requirements	**Standard Option**
Please remember that you must call 517-364-8567 or 866-539-3342 to get authorization to receive these Benefits in advance of any inpatient treatment and certain outpatient services including, but not limited to: • Intensive outpatient • Intermediate • Day treatment • Partial hospitalization • ECT • Extended psychotherapy (more than 50 minutes) • Neuro, cognitive, and psych testing	

Authorization requirements - continued on next page

Benefit Description	You pay
Authorization requirements (cont.)	**Standard Option**
Without authorization, Non-Network Benefits for an inpatient stay will be reduced to 50% of Eligible Expenses.	
Not covered	**Standard Option**
• *Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.* • *Services utilizing methadone treatment as maintenance, L.A.A.M (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.* • *Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Behavioral Health Designee.* • *Residential treatment services.* • *Network Benefits for services or supplies not consistent with the Behavioral Health Designee's level of care guidelines or best practices as modified from time to time.*	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible for the Standard Option.
- Medco is PHPMM's pharmacy benefit manager. You must use Medco for mail order prescriptions. For more information about your prescription drug benefit, visit www.medco.com or call Customer Service at 517-364-8567 or 866-539-3342.

Be sure to read Section 4, *Your cost for covered services,* for valuable information about how cost-sharing works.

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

- **Who can write your prescription.** A licensed physician or dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Network pharmacy or by mail.
- **We use a formulary.** We cover non-formulary drugs only if they are prescribed by a Physician AND your physician has received authorization from us.

There are dispensing limitations. For more information on the dispensing limits of each medication, go to www.medco.com or call Customer Service at 517-364-8567 or 866-539-3342.

Why use generic drugs? A generic medication is basically a copy of a brand-name medication. The color or shape may be different, but the active ingredients must be the same for both. Only the Food and Drug Administration (FDA) tests and allows a generic medication to be made.

Special types of drug coverage for retail and mail-order pharmacies. There are special classes of drugs that are covered at a different level than other Prescription Drug Products. They are Prescription Drug Products for:

- The treatment of infertility - You pay 40% of the Prescription Drug Cost per Prescription Order or Refill.
- Growth hormone therapy - You pay 40% of the Prescription Drug Cost per Prescription Order or Refill.
- The treatment of obesity - You pay 50% of the Prescription Drug Cost per Prescription Order or Refill for a Covered Person who qualifies under our current "Prescription Weight Loss Medication Policy."

Benefit Description	You pay
Three-Tier Benefit Plan	**Standard Option**
Your Copayment is determined by the tier to which we have assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please access www.medco.com through the Internet, or call Customer Service at 517-364-8567 or 866-539-3342 to determine tier status. • Tier-1 Drugs are generally generic • Tier-2 Drugs are generally brand-name • Tier-3 Drugs are generally non-preferred drugs	

Benefit Description	You pay
Prescription Drugs from a Mail-Order Network Pharmacy	**Standard Option**
Benefits are provided for outpatient Prescription Drug Products dispensed by Medco. The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. To receive the maximum Benefit, ask your Physician to write your prescription order or refill for a 90-day supply with refills when appropriate.	Tier-1 - $30 per prescription order or refill Tier-2 - $50 per prescription order or refill Tier-3 - $100 per prescription order or refill
Prescription Drugs from a Retail Network Pharmacy	**Standard Option**
Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	Tier-1 - $15 per prescription order or refill Tier-2 - $25 per prescription order or refill Tier-3 - $50 per prescription order or refill
Not covered (for both retail and mail order drugs): • *Outpatient Prescription Drug Products obtained from a Non-Network pharmacy, except as required for Emergency treatment.* • *Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.* • *Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.* • *Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.* • *Drug not approved by the federal Food and Drug Administration (FDA).* • *General vitamins, except the following which require a prescription order or refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.* • *Compounded drugs that do not contain at least one ingredient that requires a prescription order or refill.*	All charges

Prescription Drugs from a Retail Network Pharmacy - continued on next page

Benefit Description	You pay
Prescription Drugs from a Retail Network Pharmacy (cont.)	**Standard Option**
• *Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 32.)	All charges

Section 5(g). Dental benefits

Important things you should keep in mind about these Benefits:

- Please remember that all Benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Network dentists must provide or arrange your care.
- The Calendar Year Deductible for the Standard Option is: $500 per person ($1,000 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 procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Dental services are covered when all of the following are true: • Treatment is medically necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D. M.D." • The dental damage is severe enough that the initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services to repair damage caused by accidental injury must contain the following time frames: • Treatment is started within three months of the accident, unless extenuating circumstances (such as prolonged hospitalization or the presence of fixation wires from fracture care).	Network or Non-Network: 20% of Coinsurance after Deductible

Accidental injury benefit - continued on next page

Benefit Description	You Pay
Accidental injury benefit (cont.)	**Standard Option**
• Treatment is completed within 12 months of the accident, or the start of treatment (unless extenuating circumstances exist). **Authorization Requirements** Please remember that you or your provider must obtain authorization from us as soon as possible, but at least five business days before follow-up (post Emergency) treatment begins. (You do not have to notify us at the time of the initial Emergency treatment.) If you don't obtain authorization from us, Non-Network Benefits will be reduced to 50% of Eligible Expenses.	Network or Non-Network: 20% of Coinsurance after Deductible
Not covered: • *Any other Dental care, including orthodontia, and all associated expenses, except as described above.*	All charges

Section 5(h). Special features

Feature	Description
Special Feature	**Standard Option**
Online Customer Claims and Personal Health Management	Web-access to view your Benefits and claims, maintain a personal health record, order ID cards, change your PCP and make address changes.
Services for deaf and hearing impaired	Services for TTY/TDD users, speech impaired or hearing impaired.
Disease Management Programs	Healthy Focus Programs: • Supports members with cardiovascular disease, asthma, diabetes, and low back pain - Educates members about self-care - Monitors members' conditions
Healthy Mom/Healthy Baby Program	To help normal and high-risk pregnant members learn to have a healthy pregnancy, delivery, and after delivery care.
Case Management	Provides resources for members with complex illnesses: • Addresses gaps in care • Provides access to specialists • Educates members about medications • Offers self-help tools and information • Follows through with clinical care • Provides support with supplies and equipment
Care Coordination	Improves relationships between doctors and patients by offering more resources than traditional health care programs, and makes it easy for patients to access the information they need about medical concerns.
Travel Benefit/Service Overseas	Benefits are available when you travel, and have an emergency situation, through PHP's extended network. You can receive access to the network by calling the number on the back of your ID card.

Section 5(i). Point of service benefits

Most medical services, with the exception of certain services, are available as Point of Service benefits.

- In Network - benefits received by a PHP network provider are considered to be Network.
- Non-Network - benefits received by a provider not in the PHP network, with the exception of Preventive Services which are not covered when received by a Non-Network provider. If you choose to see a Non-Network provider, you will pay a higher precentage Coinsurance.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the Plan at 517-364-8567 or 866-539-3342 or visit their website at www.phpmm.org.

Non-FEHB Benefits	Standard Option
Michigan Athletic Club Discount	As a PHP member, you are eligible for a discount at the Michigan Athletic Club.

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

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

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, or those excluded in any other section of this brochure.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not Medically Necessary.
- Alternative treatments as defined by the National Center for Complimentary and Alternative Medicine (NCCAM), a component of the National Institutes of Health.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself; and services performed by a provider with your same legal residence.
- Supplies, equipment and similar incidental services and supplies for personal comfort, or for the convenience of either the Covered Person or his or her Physician - including, but not limited to television, telephone, beauty/barber service, guest services.
- Experimental, Investigational and Unproven services, procedures, treatments, drugs or devices. The fact that an Experimental, Investigational, or Unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while on active military service.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage.
- Health services provided in a foreign country, unless required as Emergency Health Services.
- Travel or transportation expenses, even though prescribed by a Physician.
- Custodial care.
- Services delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Network physicians, receive services at Network hospitals and facilities, or obtain your prescription drugs at participating 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 services from Non-Network providers. Sometimes these providers bill us directly. Check with the provider.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 517-364-8567 or 866-539-3342, or at our Web site at www.phpmm.org.

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

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

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

Submit your claims to:

Customer Service, Physicians Health Plan, P.O. Box 30377, Lansing, MI 48909-7877

Prescription Drugs

Submit your claims to: Customer Service, Physicians Health Plan, P.O. Box 30377, Lansing, MI 48909-7877

Other supplies and services

Submit your claims to: Customer Service, Physicians Health Plan, P.O. Box 30377, Lansing, MI 48909-7877

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

Authorized Representative

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Physicians Health Plan, PO Box 30377, Lansing MI 48909-7877; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or. c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3	If you do not agree with our decision, you may ask OPM to review it.
	You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information.
	Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.
	Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.
	If you do not agree with OPM's decision, your only recourse is to 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 you did not indicate that your claim was a claim for urgent care, then call us at (517) 364-8567 or 866-539-3342. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance (HI) 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE(1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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, 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's toll-free number, 1-800-772-1213 SSA TTY number (1-800-325-0778), to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

(Please refer to page 66 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

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

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 517-364-8500 or see our Web site at www.phpmm.org.

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

You can find more information about how our plan coordinates benefits with Medicare on our Web site at www.phpmm.org.

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide Benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Clinical Trials

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

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

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Alternate Facility

A health care facility that is not a Hospital, or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services
- Emergency Health Services
- Urgent Care health facilities
- Pre-scheduled rehabilitative, laboratory or diagnostic services

An Alternate Facility may also provide Mental Health Services on an outpatient, intermediate or inpatient basis.

Benefits

Your right to payment for Covered Health Services that are available in this Brochure. Your right to Benefits is subject to the terms, conditions, limitations and exclusions listed in this Brochure.

Calendar year

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

Chiropractor

Any doctor of chiropractic who is duly licensed and qualified to provide chiropractic services.

Clinical Trials Cost Categories

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.

Congenital Anomaly

A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment

The charges stated as a set amount you are required to pay for certain Covered Health Services. See page 15.

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Services

Those health services determined by us to be Medically Necessary as determined per PHPMM Medical Policy and nationally recognized guidelines and provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms, and which are described in this brochure as being covered.

Covered Person

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled. References to "you" and "your" throughout this Brochure are references to a Covered Person.

Custodial Care

Services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services, which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or

- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible

The amount you must pay for Covered Health Services and supplies in a Calendar Year before we start paying Benefits for those services and supplies in that Calendar Year. Amounts paid toward the annual Deductible for Covered Health Services and supplies that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the annual Deductible.

Designated Facility

A facility that has entered into an agreement on behalf of the facility and its affiliated staff with us or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment

Medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to service a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is of use to a person only in the presence of a disease or physical disability.
- Is appropriate for use in the home.
- Is not implantable within the body.

Eligible Expenses

The amount we will pay for Covered Health Services, is determined as stated below:

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from Non-Network providers as a result of an Emergency or as otherwise arranged by your Primary Care Physician or other Network Physician and approved by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

For Non-Network Benefits, Eligible Expenses are determined, at our discretion, based on:

- Available data resources of competitive fees in that geographic area, or
- Fee(s) that are negotiated with the provider; or
- 100% of the billed charge; or
- A fee schedule that we develop.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Emergency

The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, or to a Pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Health Services

Health care services and supplies necessary for the treatment of an Emergency.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Any service billed with a temporary procedure code.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Health care professional

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

Home Health Agency

A program or organization authorized by law to provide health care services in the home.

Hospital

An institution, operated as required by law that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury

Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility

A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay

An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intermediate Care

The use of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals who are physiologically or psychologically dependent upon or abusing alcohol or drugs:

- Chemotherapy.
- Counseling.

- Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Medically Necessary

Health care services and supplies, which are determined by us to be medically appropriate per PHPMM Medical Policy and nationally recognized guidelines, and

- Not Experimental or Investigational Services; and
- Necessary to meet the basic health needs of the Covered Person; and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Health Service; and
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by us; and
- Consistent with the diagnosis of the condition; and
- Required for reasons other than the convenience of the Covered Person or his/her Physician; and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,
  - Safe with promising efficacy:
  - For treating a life-threatening Sickness or condition; and
  - In a clinically controlled research setting; and
  - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term "life threatening" is used to describe Sickness or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an Injury, Sickness, or Mental Illness, or the fact that the Physician has determined that a particular health care service or supply is medically necessary or medically appropriate does not mean that the procedure or treatment is a Covered Health Service. The definition of Medically Necessary used in this Brochure relates only to Benefits and may differ from the way in which a Physician engaged in the practice of medicine may define Medically Necessary.

Mental Health Services

Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnosis and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee

The organization or individual designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available.

Mental Illness

Those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded in this Brochure.

Network

When used to describe a provider of health care services, this means a provider that has a participation agreement in effect with us or with our affiliate to (either directly or indirectly) to participate in our Network. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits

Benefits for Covered Health Services that are provided by or under the direction of a Network Physician in a Network Physician's office or at a Network facility. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility by a Network Physician or other Network provider. Network Benefits include Emergency Health Services.

Non-Network Benefits

Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider, or Covered Health Services that are provided at a Non-Network facility.

Out-of-Pocket Maximum

The maximum amount of annual Deductible and Coinsurance you pay every Calendar Year. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that Calendar Year. Once you reach the Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that Calendar Year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify us as required.
- Charges that exceed Eligible Expenses.
- Copayments.
- The annual Deductible.

Physician

Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.," who is properly licensed and qualified by law.

Please note: Any nurse practitioner, physician assistant, podiatrist, dentist, psychologist, Chiropractor, optometrist, nurse midwife, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are covered.

Plan Allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. See the definition of Eligible Expenses for an explanation of how Plan Allowance is determined.

Post-Service Claims

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

Pre-Service Claims

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

Preferred Tobacco Cessation Products

PHP's select list of prescription and over-the-counter drugs that are covered for the treatment of tobacco dependence or addiction.

Pregnancy

Includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complication associated with Pregnancy.

Prescription Drug List A list that identifies those Prescription Drug Products for which Benefits are available under this Plan. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per Calendar Year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.medco.com or by calling 517-364-8567 or 866-539-3342.

Prescription Drug Product A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of this Brochure, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
  - control solutions and combo kits;
  - glucose monitors.

Primary Care Physician A Network Physician that you select to be responsible for providing or coordinating all Covered Health Services for Network Benefits. A Primary Care Physician has entered into an agreement with us to provide primary care health services to Covered Persons. The majority of his or her practice generally includes pediatrics, internal medicine, obstetrics/gynecology, or family or general practice.

Recreational Therapy Inpatient or outpatient recreational activities that may be considered to serve a therapeutic purpose including, but not limited to, camp or camping events, sports or sporting events, horseback riding, art therapy services or art instruction, music therapy services or music instruction, boating or other recreational activities.

Semi-private Room A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is medically necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area The geographic area we serve and that has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve.

Sickness Physical illness, disease or Pregnancy. The term Sickness as used in this Brochure does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility A Hospital or nursing facility that is licensed and operated as required by law.

Substance Abuse Services

Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnosis and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnosis and Statistical Manual of the American Psychiatric Association does not mean that the treatment of the disorder is a Covered Health Service. Substance Abuse Services include services for the prevention, treatment and rehabilitation for Covered Persons who take alcohol or other drugs at dosages that place the individual's social, economic, psychological, and physical welfare in potential hazard, or to the extent that an individual loses power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Unproven Services

Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted, randomized, controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose, which treatment is received.)
- Well-conducted, cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted, randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center

A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Urgent care claims

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

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 517-364-8567 or 866-539-3342. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Physicians Health Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies 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 Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

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

You can find additional information at www.opm.gov/insure .

- **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 2012 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 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, 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 26, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from 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; 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.

Section 12. Other Federal Programs

Important informationabout three Federal programs that complement the FEHB Progam

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any 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 tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is, separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All Dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) service with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

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

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/lvision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

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

Health Insurance Plan of Michigan (HIP Michigan)

Do you know someone who needs health insurance but can't get it? The Health Insurance Plan (HIP Michigan) may help.

An individual is eligible to buy coverage in HIP Michigan if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;

- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

To find out about eligibility, visit www.hipmichigan.com or call 517-364-8203 or 877-459-3113.

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

Summary of benefits for the Standard Option of Physicians Health Plan - 2012

- 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.
- Below, and asterisk (*) means the item is subject to the $500/$1,000 Network, $1,000/$2,000 Non-Network Deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by Physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: $20 (Network), Not covered (Non-Network)	20
Services provided by a Hospital:		
• Inpatient	20% Coinsurance after Deductible (Network), 30% Coinsurance after Deductible (Non-Network) *	42
• Outpatient	20% Coinsurance after Deductible (Network), 30% Coinsurance after Deductible (Non-Network)*	43
Emergency Benefits (Network or Non-Network):		
• In a Physician's Office	$20 per visit	45
• Urgent care	$30 per visit	45
• In an Emergency Room	$60 per visit; waived if admitted	45
Mental health and substance abuse treatment:	Regular cost-sharing	47
Prescription drugs:		
• Retail pharmacy	$15/$25/$50 per prescription filled	51
• Mail order	$30/$50/$100 per prescription filled	51
Dental care:		
• Accidental injury	The appropriate Copayment or Coinsurance may apply.	53
Vision care:		
• Annual eye exams	$20 copay per eye exam (Network), Not covered (Non-Network)	25
Hearing care:		
• Hearing aid and testing	Nothing, Benefit limited to $880 for monaural/ $1,600 for binaural hearing aid per three year period	25
Special features:		

Standard Option Benefits	You Pay	Page
• Disease management programs • Healthy Mom/Healthy Baby program • Travel benefit/service overseas • Educational classes and programs		55
Protection against catastrophic costs (Out-of-Pocket Maximum)**:**	Nothing after $1,500 per person/$3,000 per family per Calendar Year (Network) Nothing after $3,000 per person/$6,000 per family per Calendar Year (Non-Network) Some costs do not count toward this protection.	15

2012 Rate Information for Physicians Health Plan Standard Option

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

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

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 *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Standard Option Self Only	9U4	$185.75	$92.96	$402.46	$201.41	$72.33	$69.75
Standard Option Self and Family	9U5	$414.35	$257.35	$897.76	$557.59	$211.31	$205.55