

Physicians Health Plan of Northern Indiana



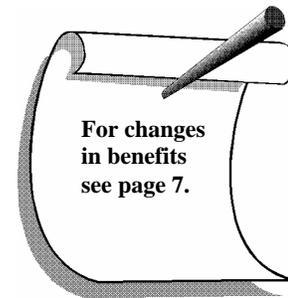
<http://www.phpni.com>

2005

A Health Maintenance Organization

Serving: Northeast Indiana

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment codes for this Plan:

DQ1 Self Only

DQ2 Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-583



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

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

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits of Physicians Health Plan of Northern Indiana, Inc., under our contract (CS 2648) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Physicians Health Plan of Northern Indiana, Inc.'s administrative office is:

Physicians Health Plan of Northern Indiana, Inc.
8101 West Jefferson Boulevard
Fort Wayne, Indiana 46804-4163

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning and Evaluation Group, 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:

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

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired; or contact us through our Website at www.phpni.com and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. 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/consumer.html. 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.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

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

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

Physicians Health Plan of Northern Indiana does not require you to choose one primary care doctor. What makes Physicians Health Plan of Northern Indiana special is that as a Plan member you will have the freedom to receive your medical care from any of the more than 1470 private practice doctors in all specialties at more than 590 locations. In addition, there are over 223 neighborhood participating pharmacies, 28 participating hospitals and over 28 urgent care and surgery facilities.

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

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

How we pay providers

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

Your Rights

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

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

If you want more information about us, call 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or write to Physicians Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804-4163. You may also contact us by fax at 260/432-0493 or visit our Web site at www.phpni.com.

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our providers practice. Our service area is where you will find Plan providers and facilities. Our service area includes the following Indiana counties:

Adams, Allen, Dekalb, Elkhart, Jay, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, and Whitley.

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

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

Section 2. How we change for 2005

Do not rely on these change descriptions; this page 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

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 120% for Self Only or by 115% for Self and Family.
- We cover retail prescriptions up to a 30-day supply. Previously, you could obtain up to a 34-day supply from a retail pharmacy. See page 37.
- The coinsurance for Durable Medical Equipment to treat sexual dysfunction has increased from 20% to 40% of the allowable charges. There is also a \$1,000 maximum payable limit per person per calendar year. See page 23.
- Prescription medication to treat sexual dysfunction will have a limit of \$1,000 maximum payable per person per calendar year. You will now pay 40% of allowable charges. Previously, these were covered under the 34-day retail copayments. See page 39.
- Prescription drugs to treat infertility have a \$1,500 maximum payable per person per calendar year. See page 39.
- Physicians do not provide house calls or home visits. See page 15.
- The \$15 office visit copay applies to allergy serum. See page 19.
- Hospice services have a lifetime maximum of 60 consecutive days per person. Previously, this was an unlimited benefit. See page 31.
- The number of days of eligibility for Extended Care/Skilled Nursing has been reduced from 60 days to 30 days maximum per person per calendar year. See page 31.
- We limit surgically implanted contraceptive (for example, Norplant) to one implant per person every five calendar years. See page 39.
- We limit custom molded foot orthotics to a \$200 lifetime maximum per person. See page 22.
- You must get pre-authorization from us for all prescription medications that cost over \$1,000 per prescription. See page 38.
- We have clarified the brochure language that we do not cover medication for weight loss. We have never provided coverage for weight loss medication. See page 39.
- We have clarified the brochure language that we cover sigmoidoscopy screening subject to the office visit copay or coinsurance. Coverage for this service has not changed. See page 16.

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 (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired or write to us at 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804. You may also request replacement cards through our Web site at www.phpni.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles and/or coinsurance, and you will not have to file claims. Please remember you may be required to pay this amount when you receive services. Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services rendered outside the service area unless there is a Plan authorization made in advance.

• Plan providers

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

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

• Plan facilities

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

What you must do to get covered care

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

• Primary care

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

If your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

A wide range of specialists are available among the Plan's more than 1470 participating doctors. You do not need a referral from a primary care doctor to see a specialist under the Plan. Consult the Plan Provider Directory or call the Customer Service Department at 260/432-6690, extension 11; 800/982-6257, extension 11; or 260/459-2600 for the hearing impaired, for a specialist near you.

Here are other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 260/432-6690, extension 11; 800/982-6257, extension 11; or 260/459-2600 for the hearing impaired. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

Your doctor must obtain our approval for the following services:

- Inpatient Services, Skilled Nursing or Other Type of Facility
- Observation
- Durable Medical Equipment
- Growth Hormone Therapy
- Transplants
- Out-of-area Physicians
- Maternity
- Sleep Studies
- Schlerotherapy
- Feta Fibronectin
- Immune Globulin
- Penile Implants
- Reconstructive Surgeries
- Behavioral Health or Substance Abuse
- Non-Emergency Ambulance Transportation
- Bariatric Treatment
- Bone Growth Stimulator
- Botox
- Capsular Endoscopy (Given)
- Cochlear Implant
- Implantable Neurostimulator
- PET Scan
- Remicade
- SalEst
- Synagis
- TMJ
- Medications that Cost \$1,000 or More Per Prescription

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments

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

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

Deductible

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

- The calendar year deductible for medical services is \$250 per person. Under a Self and Family enrollment, we consider the deductible satisfied and pay benefits for all family members when the family's combined covered deductible amounts reach \$500 during that calendar year.
- We also have a separate deductible for mental health and substance abuse benefits. The calendar year deductible is \$250 per person and \$500 per family.

Coinsurance

Coinsurance is the percentage of covered charges that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

Your catastrophic protection out-of-pocket maximum

Medical Treatment

Once you have satisfied your deductible and your coinsurance totals \$1,000 per person or \$2,000 per family in a calendar year, you do not have to pay any more coinsurance for covered medical services. However, copayments and/or coinsurance for the following services do not count toward your medical catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

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

Mental Health and Substance Abuse Treatment

Once you satisfy your deductible and your coinsurance for Mental Health/Substance Abuse services totals \$1,000 per person or \$2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Office Visits
- Prescription Drugs
- Emergency Room Charge
- Urgent Care

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

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 63 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or through our Web site at www.phpni.com.

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

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Here are some important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan doctors must provide or arrange your care.
- The calendar year deductible is: \$250 per person or \$500 per family and applies to services when you pay a percentage of charges. The deductible for medical services is separate from the deductible for mental health and substance abuse services. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your catastrophic protection out-of-pocket maximum. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.

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

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRIs • Ultrasound • Electrocardiogram and EEG 	20% of Charges
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult test • Routine Prostate Specific Antigen (PSA) test • Routine Pap Test • Routine mammogram <p>Note: No deductible</p> <p>Note: Maximum benefit payable for routine screenings listed above is one each per person per calendar year that we pay in full.</p>	Nothing
<p>Routine immunizations in the doctor's office</p> <p>Note: No deductible</p>	\$15 per office visit
<p>Routine Colorectal Cancer Screening, including:</p> <ul style="list-style-type: none"> • Sigmoidoscopy, screening 	\$15 per office visit; otherwise, 20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams & immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel or examinations that are not necessary for medical reasons</i> 	<i>All charges</i>

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunization and care • Examinations, such as: <ul style="list-style-type: none"> – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations <p>Note: No deductible</p>	\$15 per office visit
<ul style="list-style-type: none"> • Eye Exams for children through age 17 to determine the need for vision correction <p>Note: No deductible</p>	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camps, or travel, or examinations that are not necessary for medical reasons</i> • <i>Eyeglasses, contacts, or related supplies</i> • <i>Eye exercises</i> 	<i>All charges</i>
Maternity care	
<p>Complete Maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • Your Plan doctor will need to precertify your maternity services; see page 29 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Circumcision is covered as a surgical procedure. See Section 5(b) <i>Surgical benefits</i>. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) <i>Hospital benefits</i> and Section 5(b) <i>Surgical benefits</i>. 	\$15 for initial office visit only; 20% of charges thereafter

Maternity care – continued on next page

Maternity care <i>(continued)</i>	You pay
<ul style="list-style-type: none"> Labs, sonograms, fetal stress tests, etc., not included in the global fee 	20% of charges
<p>Specialized obstetrical services such as:</p> <ul style="list-style-type: none"> Amniocentesis Corionic Villi Sampling 	\$15 per office visit when performed in the doctor's office; otherwise, 20% of charges
<p><i>Not covered: Routine sonograms to determine sex.</i></p>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See <i>Surgical procedures</i> Section 5(b)) Injectable contraceptive drugs Intrauterine devices (IUDs) Diaphragms <p>Note: No deductible</p> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$15 per office visit
<p>Surgically implanted contraceptive such as Norplant</p> <p>Note: No deductible</p> <p>Note: Norplant is considered a commonly used "surgically" implanted device. Maximum benefit payable for Norplant is one implant per person every five calendar years.</p>	40% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling</i> 	<i>All charges</i>

Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> –intra vaginal insemination (IVI) –intra cervical insemination (ICI) –intra uterine insemination (IUI) <p>Note: No deductible</p> <p>Note: We cover up to a 14-day supply of infertility medicines unless limited by drug manufacturer’s packaging, per prescription or refill under the <i>Prescription drug benefit</i> (See Section 5(f)). Maximum benefit payable for Infertility drugs is \$1,500 per person per calendar year. The calendar year maximum applies to all infertility drugs including those medications purchased at a pharmacy or injected in your physician’s office.</p>	40% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete GIFT and zygote ZIFT</i> – <i>zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>
Allergy care	
<p>Testing and treatment</p> <p>Note: No deductible</p>	\$15 per office visit
<p>Allergy injection</p> <p>Allergy serum</p> <p>Note: No deductible</p>	Nothing if you receive these services during your office visit; otherwise, \$15 per office visit
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges</i>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <p>Note: Respiratory and Inhalation therapy, home intravenous (IV) therapy, and antibiotic therapy are covered as <i>Home health services</i>. Please see page 24.</p> <p>Note: We cover growth hormone therapy under the <i>Prescription drug benefits</i>. Please see page 38.</p>	20% of charges
<p><i>Not covered: Experimental, investigational or unproven services, treatments, supplies, drugs, devices, and procedures</i></p>	All charges
Physical and occupational therapies	
<ul style="list-style-type: none"> • 62 visits per condition per calendar year for the services of each of the following: <ul style="list-style-type: none"> - licensed physical therapists and - occupational therapists • Cardiac rehabilitation <p>Note: We only cover physical or occupational therapies to restore bodily function due to illness or injury for up to two months per condition if significant improvement can be expected. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p> <p>Note: Cardiac rehabilitation includes Phase I and Phase II treatments.</p>	\$15 per office visit when performed in the doctor's office; otherwise, 20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehab therapy • Exercise programs • Developmental therapies 	All charges
Speech therapy	
<p>Up to 20 visits of speech therapy services per calendar year from a licensed speech therapist</p> <p>Note: We cover habilitative or rehabilitative speech therapy.</p>	\$15 when performed in the doctor's office; otherwise 20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Developmental therapies • Behavior disorder • Stuttering/stammering • Tongue thrust 	All charges

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

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device <p>Note: Maximum benefit payable for prosthetic devices is \$5,000 per person per calendar year. All prosthetic devices related to a covered mastectomy are not subject to this maximum.</p>	20% of charges
<ul style="list-style-type: none"> • Custom molded foot orthotics to be placed in shoes if ordered and/or provided by a Plan doctor <p>Note: No deductible</p> <p>Note: Orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, under <i>Durable Medical Equipment</i>, if we approve them in advance. (See Section 5(a))</p> <p>Note: Lifetime maximum benefit payable for custom molded foot orthotics is \$200 per person.</p>	40% of charges
<ul style="list-style-type: none"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) dysfunction <p>Note: This benefit service is in combination with other TMJ services. See <i>Oral and maxillofacial surgery</i>.</p>	40% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Repair or replacement of any non-medically necessary prosthetic devices</i> 	<i>All charges</i>

Durable medical equipment (DME)	You pay
<p>Rental up to purchase price, or purchase at our option, of durable medical equipment prescribed by your Plan doctor, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • standard wheelchairs; • crutches; • walkers; • blood glucose monitors; • insulin pumps; and • orthopedic and corrective shoes that are an integral part of a brace may be covered equipment, if we approve them in advance. <p>Note: No deductible</p> <p>Note: Call us at 260/432-6690, extension 11; 800/982-6257, extension 11; or 260/459-2600 for the hearing impaired as soon as your Plan doctor prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of charges</p>
<p>Ostomy Supplies</p> <p>Note: No deductible</p> <p>Note: Ostomy Supplies are covered when used for the care of an artificial stoma or opening into the urinary, gastrointestinal canal and/or the trachea.</p> <p>Note: Maximum benefit payable for Ostomy Supplies is \$500 per person per calendar year.</p>	<p>40% of charges</p>
<p>Durable Medical Equipment to treat sexual dysfunction such as but not limited to penile implants and vacuum pumps</p> <p>Note: No deductible</p> <p>Note: Maximum benefit payable for covered sexual dysfunction durable medical equipment is \$1,000 per person per calendar year.</p> <p>Note: We cover certain drugs to treat sexual dysfunction under the <i>Prescription drug benefit</i>; see section 5(f) subject to a separate \$1,000 benefit maximum.</p>	<p>40% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchairs, scooters, lifts for wheelchairs, or motor vehicles</i> • <i>Repair or replacement of any non-medically necessary DME</i> • <i>Batteries to operate DME</i> • <i>Common household articles such as: air conditioners, humidifiers, and air purifiers</i> • <i>Disposable or non-durable medical supplies such as: elastic bandages, elastic support, and gauze</i> 	<p><i>All charges</i></p>

Home health services	You pay
<ul style="list-style-type: none"> Home health care ordered by a Plan doctor and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide Services include oxygen therapy, intravenous therapy, antibiotic therapy, and medications if provided by a Plan home health care agency <p>Note: No deductible</p> <p>Note: Services such as physical and occupational therapy or durable medical equipment are subject to copayments or coinsurance. See also <i>Physical and occupational therapies, Speech therapy, and Durable medical equipment (DME)</i>.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> <i>Custodial care</i> 	<i>All charges</i>
Chiropractic	
<ul style="list-style-type: none"> No benefit 	<i>All charges</i>
Alternative treatments	
<ul style="list-style-type: none"> No benefit 	<i>All charges</i>
Educational classes and programs	
<p>Coverage is limited to diabetes self-management training, meeting these minimum requirements:</p> <ul style="list-style-type: none"> One visit after receiving a diagnosis of diabetes One visit after receiving a diagnosis that: <ul style="list-style-type: none"> represents a significant change in the patient's symptoms or condition; and makes a change in self-management necessary. One visit for refresher or re-education training 	\$15 when performed in the doctor's office; otherwise 20% of charges

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

Here are some important things you should keep in mind about these benefits:

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan doctors must provide or arrange your care.
- The calendar year deductible is \$250 per person or \$500 per family and applies to services when you pay a percentage of charges. The deductible for medical services is separate from the deductible for mental health and substance abuse services. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by a Plan doctor 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 DOCTOR MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the pre-certification information shown in Section 3.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your catastrophic protection out-of-pocket maximum. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.

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

Surgical procedures - continued on next page

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity- a condition in which an individual weighs at least two (2) times the ideal weight for frame, age, height, and gender. See note below. • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information such as: artificial knuckles and joints, pacemakers, insulin pump, defibrillator. See note below. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: We cover non-experimental, surgical treatment of morbid obesity that has persisted for at least five (5) years and you have received non-surgical treatment supervised by a doctor for at least 18 consecutive months that has been unsuccessful.</p> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per office visit for surgery performed in the doctor’s office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor’s office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot. (See Foot care)</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance, and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes. 	<p>\$15 per office visit for surgery performed in the doctor’s office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor’s office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per office visit for surgery performed in the doctor’s office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor’s office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>

Reconstructive surgery – continued on next page

Reconstructive surgery (<i>continued</i>)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$15 per office visit for surgery performed in the doctor’s office; otherwise 20% of charges</p> <p>Note: All surgeries cannot be performed in the doctor’s office and must be performed in an outpatient facility such as a hospital or ambulatory surgery center.</p>
<ul style="list-style-type: none"> • Treatment for services of Temporomandibular joint dysfunction (TMJ) <p>Note: This benefit service is in combination with all TMJ services.</p>	<p>40% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Treatment of overbite or underbite, maxillary and mandibular osteotomies, dental x-rays, dental supplies, and appliances and all associated expenses</i> • <i>Orthodontic treatment or braces for teeth</i> 	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, and advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplant (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas <p>Note: We use a National Transplant Program (NTP) – United Resource Networks (URN). Transplant services must be provided and arranged by a Plan doctor and performed at a designated transplant facility.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>\$15 per office visit; 20% of charges for transplant procedure</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs involving mechanical or animal origins</i> • <i>Transplants not listed as covered</i> • <i>Solid organ transplants performed as a treatment for cancer</i> 	<p><i>All charges</i></p>
<p>Anesthesia</p>	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department or other facility • Skilled nursing facility 	<p>20% of charges</p>
<ul style="list-style-type: none"> • Office <p>Note: No deductible</p>	<p>\$15 per office visit</p>

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

Here are some important things you should keep in mind about these benefits:

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan doctors must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is \$250 per person or \$500 per family and applies to services when you pay a percentage of charges. The deductible for medical services is separate from the deductible for mental health and substance abuse services. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- The amounts listed below are for the charges billed by a facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., doctors, etc.) are covered in Sections 5(a) or (b).
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your catastrophic protection out-of-pocket maximum. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.
- **YOUR DOCTOR MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3.

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Benefit Description	You pay
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
<p>Inpatient hospital</p> <p>Room and board, such as:</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services 	<p>20% of charges</p>

Inpatient hospital – continued on next page

Inpatient hospital <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Diagnostic laboratory tests, X-rays, and pathology services <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. See Section 5(h) <i>Accidental injury benefit</i>.</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Blood and blood derivatives not replaced by the member</i> 	<i>All charges</i>

Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Extended care benefits/skilled nursing care or other type of facility benefits:</p> <ul style="list-style-type: none"> • 30-days per calendar year for confinement in an approved inpatient transitional care unit when ordered by a participating doctor. <ul style="list-style-type: none"> - bed, board and general nursing care (semi-private room) - drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the extended care/skilled nursing facility. <p>Note: No deductible</p> <p>Note: Maximum benefit payable for extended care benefits/skilled nursing care or other type of facility benefits is 30 days per person per calendar year.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Custodial care</i> 	<i>All charges</i>
Hospice care	
<p>Inpatient and outpatient Hospice care</p> <p>Family counseling</p> <p>Note: No deductible</p> <p>Note: These services are provided under the direction of a Plan doctor who certifies the patient to be terminally ill with six months or less to live.</p> <p>Note: Lifetime maximum benefit payable for Hospice care is 60 consecutive days per person.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Funeral arrangements</i> • <i>Pastoral bereavement or legal counseling</i> • <i>Respite care</i> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Custodial care</i> 	<i>All charges</i>

Ambulance	You pay
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate <p>Note: No deductible</p> <p>Note: Non-emergency ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved in advance by PHP.</p>	<p>20% of charges</p>

Section 5(d) Emergency services/accidents

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$250 per person or \$500 per family and applies to services when you pay a percentage of charges. The deductible for medical services is separate from the deductible for mental health and substance abuse services. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your catastrophic protection out-of-pocket maximum. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.

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What is a medical emergency?

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

What to do in case of emergency:

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

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

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

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

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

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office 	\$15 per office visit
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	\$30 per urgent care center visit
<ul style="list-style-type: none"> • Emergency room care at a hospital, including doctors’ services <p>Note: You are responsible for 20% of inpatient and certain outpatient hospital services such as labs and x-rays. See Sections 5(a), 5(b), and 5(c).</p>	\$75 per hospital emergency room visit

Emergency within our service area – continued on next page

Emergency within our service area <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>All follow-up care not approved by the Plan or provided by a Plan provider</i> 	<p><i>All charges</i></p>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office 	<p>\$15 per office visit</p>
<ul style="list-style-type: none"> • Emergency care at an urgent care center 	<p>\$30 per urgent care center visit</p>
<ul style="list-style-type: none"> • Emergency room care at a hospital, including doctors' services <p>Note: You are responsible for 20% of inpatient and certain outpatient hospital services such as labs and x-rays. See Sections 5(a), 5(b), and 5(c).</p>	<p>\$75 per hospital emergency room visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> • <i>All follow-up care not approved by the Plan or provided by a Plan provider</i> 	<p><i>All charges</i></p>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: No deductible</p> <p>Note: Non-emergency or air ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved by PHP.</p>	<p>20% of charges</p>

Section 5(e) Mental health and substance abuse benefits

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

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is \$250 per person or \$500 per family and applies to services when you pay a percentage of charges. The deductible for medical services is separate from the deductible for mental health and substance abuse services. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- After you have met your mental health and substance abuse catastrophic protection out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your catastrophic protection out-of-pocket maximum. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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

Mental health and substance abuse benefits – continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not authorized or approved</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>

Preauthorization

You must follow your treatment plan and all of our network authorization processes in order for us to cover your care. These include:

- You must use a Plan provider and show them your ID card.
- Your Plan provider will contact PHP for all services including pre-certification.
- We list mental health and substance abuse Plan providers in the Provider Directory that we update periodically. This list is also in our Web site.
- To obtain more information about our benefits or to obtain a Provider Directory, contact us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired; or through our Web site at www.phpni.com.

Section 5(f) Prescription drug benefits

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Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply to prescription drug benefits.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- The catastrophic protection out-of-pocket maximum does not apply to prescription drugs. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.

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- **There are important features you should be aware of.** These include:
- **Who can write your prescription.** Any physician with a valid Drug Enforcement Agency number can write your prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail from the Plan's mail-order pharmacy.
- **We use a formulary.** A formulary is a list of prescription drugs that PHP encourages doctors to prescribe when appropriate. PHP develops this formulary with the help of PHP doctors. Doctors can prescribe any medication they choose. We cover non-formulary drugs prescribed by a doctor. However, if the drug is non-formulary, patients may have a higher copayment. We encourage you to discuss with your Plan doctor the medications being prescribed to you. Plan doctors may submit a prior authorization form to PHP for review if a formulary medication has not worked for you in the past. If approved, the brand name formulary copayment will apply. You are to confirm with your doctor the determination of PHP's review.

We have an open formulary. If your doctor believes a name brand product is necessary or there is no generic available, your doctor may prescribe a name brand drug from our formulary list. The brand name formulary copayment will apply. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug formulary brochure, call 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired; or visit our Web site at www.phpni.com (click on Pharmacy icon).
- **These are the dispensing limitations.** Generally, prescribed drugs will be dispensed for up to a 30-day supply or 240 milliliter of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin).

If you use certain Prescription Drugs on an extended basis, you may wish to obtain larger quantities through the Plan's mail-order benefit. Through mail-order, you may obtain up to a 90-day supply. Your refill order may be rejected if you send it too soon after the previous one was filled. For example, 80% of your prescription order needs to be used before it can be resubmitted for refill. If you are in the military and you are called to active duty, please contact us if you need assistance filling your prescription before your departure.

A generic equivalent will be dispensed if it is available, unless your doctor specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your doctor has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic as well as the applicable copay.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **We cover certain prescription drugs in limited quantities.** Such drugs include but are not limited to: Viagra, Muse, and Caverject. Please contact the Plan for dosage limits.

Prescription drug benefits – continued on next page

Prescription drugs (*continued*)

- **When you do have to file a claim.** If you are out of the area and have an emergency where there is no Plan pharmacy, then you may have to pay for the prescription and send the Plan a letter of explanation with your receipt.
- **Pre-authorization** is required on certain medications. If your doctor wants to prescribe one, he or she will submit a preauthorization request to PHP before the drug is dispensed. Such drugs include but are not limited to: nail fungus treatments, growth hormone, multiple sclerosis medications and those medications that cost over \$1,000 per prescription.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan doctor and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> • Diabetic supplies • Drugs and medicines that by Federal law of the United States require a doctor’s prescription for their purchase • Insulin (with a copayment applied to each vial) • Disposable needles and syringes needed to inject prescribed diabetes medications • Contraceptive drugs and devices • Growth Hormone Therapy (GHT) <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable contraceptive drugs are covered under Section 5(a).</p> <p>Note: Call 260/432-6690, extension 11, for preauthorization for Growth Hormone Therapy (GHT). We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3. Plan doctor will periodically review the program for continuing appropriateness and need.</p>	<p>\$10 generic per prescription unit</p> <p>\$20 brand name formulary per prescription unit</p> <p>\$40 brand name non-formulary per prescription unit</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You pay
<p>Mail-order:</p> <p>Up to a 90-day supply of certain prescription maintenance drugs that you use on an extended basis.</p> <p>Note: Nail fungus drugs, infertility drugs, and sexual dysfunction drugs are not available through the mail-order program.</p>	<p>\$20 generic per prescription unit</p> <p>\$40 brand name formulary per prescription unit</p> <p>\$80 brand name non-formulary per prescription unit</p>
<p>Norplant and other internally implanted time-released medications</p> <p>Note: There will be no refund of any portion of these charges if the implanted time-released medication is removed before the end of its expected life.</p> <p>Note: Maximum benefit payable for Norplant and other internally implanted time-released medications is one implant per person every five calendar years.</p>	<p>40% of charges per implantation</p>
<p>All Infertility drugs</p> <p>Note: Up to a consecutive 14-day supply of medication, unless limited by drug manufacturer's packaging per prescription, order, or refill. Fertility drugs are not available through the mail-order program.</p> <p>Note: Maximum benefit payable for infertility drugs is \$1,500 per person per calendar year.</p> <p>Note: We cover certain infertility services under the <i>Infertility services benefit</i>. (See Section 5 (a)).</p>	<p>40% of charges</p>
<p>Sexual dysfunction prescription drugs</p> <p>Note: We limit these prescription drugs to a 6-dose supply per month.</p> <p>Note: Maximum benefit payable for sexual dysfunction drugs is \$1,000 per person per calendar year.</p> <p>Note: We cover certain durable medical equipment to treat sexual dysfunction. (See Section 5 (a) <i>Durable medical equipment</i>)</p>	<p>40% of charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs to enhance athletic performance</i> • <i>Smoking cessation drugs and medication, including nicotine patches</i> • <i>Vitamins, nutrients and food supplements even if a Plan doctor prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Drugs and products used for weight loss or appetite suppression, unless prescribed for narcolepsy or hyperkinesias</i> 	<p><i>All Charges</i></p>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	<p>A Telecommunication Device for the Deaf (TDD) is available for the deaf and hearing impaired by calling PHP at 260/459-2600.</p>
High risk pregnancies	<p>PHP case managers will work with your Plan doctor to coordinate services necessary for the management of your high-risk pregnancy. A PHP case manager could contact you to discuss your medical needs, services available, and to answer benefit questions.</p>
Centers of excellence	<p>When your Plan doctor contacts PHP regarding your transplantation, a PHP case manager will provide beneficial information regarding PHP's Designated Transplant Facilities. A PHP case manager will contact you or your designee to coordinate your care and answer benefit questions related to your transplant.</p>
Travel benefit/services overseas	<p>You will have coverage for emergency services while traveling. Please refer to Section 5(d) for benefit information. If overseas, you may be required to pay for services rendered. If submitting to PHP for payment, you will need to have your itemized bills and receipts converted to U.S. currency (if applicable), provide an explanation of the services, and include member information from your ID card, for payment consideration.</p>

Section 5(h) Dental benefits

Here are some important things to keep in mind about these benefits:

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$250 per person or \$500 per family. The calendar year deductible applies to all benefits in this Section.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for *Inpatient hospital benefits*. We do not cover the dental services unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *Coordinating benefits with other coverage*, including with Medicare.
- After you have met your catastrophic protection out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your catastrophic protection out-of-pocket maximum. See Section 4, *Your catastrophic protection out-of-pocket maximum*, for more information.

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Accidental injury benefit	You pay
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. Services must be provided within 12 months of the accident.	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Injury to the teeth caused by eating, chewing, or biting.</i> • <i>Services provided after 12 months of the accident</i> • <i>Temporary prosthetics including but not limited to:</i> <ul style="list-style-type: none"> – <i>partial or full dentures or bridges or</i> – <i>replacement prosthesis</i> – <i>manipulative, corrective or cosmetic adjustments of the teeth</i> – <i>orthodontia services</i> • <i>Any other dental services</i> 	<i>All charges</i>

Dental benefits

We have no other dental benefits.

Section 5(i) 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.

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

- Smoking Cessation – a reimbursement program for members who utilize any type of therapy for smoking cessation in order to successfully stop smoking for a duration of not less than one year after therapy has stopped. Therapies include: nicotine patches, nicotine gum, nicotine inhalers and/or classes. For more information, please contact us 260/432-6690, Extension 11; 800/982-6257, Extension 11; 260/459-2600 for the hearing impaired or through our Web site at www.phpni.com.
- Weight Loss – a reimbursement program for members who are concerned with weight loss. Your program must include a Plan doctor to monitor your weight loss. For more information, please contact us 260/432-6690, Extension 11; 800/982-6257, Extension 11; or 260/459-2600 for the hearing impaired or through our Web site at www.phpni.com.

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

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

When you see Plan doctors, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

You will only need to file a claim when you receive emergency services from non-plan doctors. Sometimes these doctors bill us directly. Check with the doctor. If you need to file the claim, here is the process:

Medical, hospital and prescription drug benefits

In most cases, Plan doctors and facilities file claims for you. Doctors must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, contact us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or through our Web site at www.phpni.com.

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

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

Submit your claims to:

**Physicians Health Plan of Northern Indiana, Inc.
8101 West Jefferson Boulevard
Fort Wayne, Indiana 46804-4163**

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within 12 months after the date of service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Physicians Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804-4163; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as Plan doctors' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E. Street, NW, Washington, D.C. 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">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; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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

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

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

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

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

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then contact us at 260/432-6690, extension 11; 800/982-6257, extension 11; 260/459-2600 for the hearing impaired, or through our Web site at www.phpni.com and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too; or
 - You can call OPM's Health Insurance Group 3 at 202/606-0755 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 have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. Our secondary portion will not allow payment for days or services that exceed our contract limits as outlined in Section 5 Benefits.

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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

• Should I enroll in Medicare?

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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. We do not waive your copayments, coinsurance, and deductibles for all services.

Claims process when you have the Original Medicare Plan-- You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

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

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

(Primary payer chart begins on next page.)

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

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

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

- **Medicare Advantage**

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) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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). We will not waive copayments and coinsurance for services that your Medicare Advantage plan does not cover. 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.

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 the program.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

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 according to plan limits.

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. Your full cooperation is required.

We may bring a lawsuit against a named recovery source necessary and appropriate action to preserve or enforce our rights under this subrogation. We shall be responsible only for those legal fees and expenses related to your recovery that we agree to in writing.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for certain covered services.
Copayment	A copay is a fixed dollar amount that you must pay directly to a provider for certain covered services (for example, office visits).
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Non-health related services such as assistance with activities of daily living or health related services that: <ul style="list-style-type: none">• Do not seek to cure;• Are provided when the medical condition of the Member is not changing;• Do not require administration by skilled, licensed medical personnel because a non-professionally qualified person can be trained to perform them.• Custodial care that lasts 90 days or more is sometimes known as long-term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.
Experimental or investigational services	The plan uses a variety of authoritative sources including: governmental regulatory agencies, scientific literature, medical experts and other recognized authorities in the medical field to determine whether medical procedures are experimental and/or investigational.
Group health coverage	The contract between PHP and the Office of Personnel Management for FEHB employees.
Medical necessity	Health Services that are determined by PHP to be <i>all</i> of the following: <ul style="list-style-type: none">• medically appropriate and necessary to meet the Member's basic health needs;• the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service;• consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;• accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate;• required for reasons other than the comfort or convenience of the member or his or her doctor;• of a demonstrated medical value in treating the condition of the Member; and• consistent with patterns of care found in established managed care environments for treatment of the particular health condition.
Plan allowance	Plan allowance is the amount we use to determine our payment and your copay and/or coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: in-network-contracted charges for Plan doctors/out-of-network the median reimbursement amount in PHP's judgment for such service in the geographical area where the service was rendered.
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 that 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. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

- **Children's Equity Act**

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

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

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

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 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 2004 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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 supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. 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 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 have information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 11 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later. In order to qualify for coverage under the FLTCIP,** you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Notes

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Summary of benefits for Physicians Health Plan of Northern Indiana - 2005

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.
- The calendar year deductible for medical services is \$250 per person and \$500 per family. The calendar year deductible for mental health and substance abuse benefits is \$250 per person and \$500 per family. The calendar year deductibles are separate.

Benefits	You pay	Page
Medical services provided by physicians:		
• Office visits	\$15 per visit	15
• Diagnostic laboratory tests and other treatment services.....	20% of charges*	
Services provided by a hospital: Inpatient or Outpatient	20% of charges*	29
Emergency benefits		
• In-area.....	\$15 per doctor's office visit; \$30 per urgent care center visit; or \$75 per hospital emergency room visit;	33
• Out-of-area.....	\$15 per doctor's office visit; \$30 per urgent care center visit; or \$75 per hospital emergency room visit	
Mental health and substance abuse treatment	Regular cost sharing*	35
Prescription drugs Up to a 30 day supply.....	\$10 generic/\$20 brand name formulary/\$40 brand name non-formulary per prescription unit or refill	37
Mail-order drugs Up to a 90 day supply of maintenance medication.....	\$20 generic/\$40 brand name formulary/\$80 brand name non-formulary per prescription unit or refill	
Dental care	All Charges	41
No benefit		
Vision care	\$20	21
Limited to one annual eye refraction for members 18 and over		
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximums).....	Nothing after \$1,000/Self Only or \$2,000 Self and Family enrollment per year	11
Some costs do not count toward this protection. The catastrophic protection out-of-pocket maximums are separate for medical and mental health/substance abuse services.		

2005 Rate Information for Physicians Health Plan of Northern Indiana

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

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

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

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	DQ1	\$131.08	\$85.01	\$284.01	\$184.19	\$154.74	\$61.35
Self and Family	DQ2	\$298.23	\$187.00	\$646.17	\$405.16	\$352.08	\$133.15