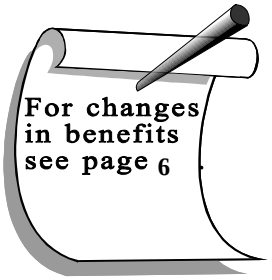
Physicians Health Plan Of Northern Indiana 2002

http://www.phpni.com

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
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

Table of Contents

Introduction

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

This brochure describes the benefits of Physicians Health Plan under our contract (CS 2648) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures 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 Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E. Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a Plan doctor, pharmacy, or hospital 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 Web site at www.phpni.com and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

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.

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

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

Your Rights

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 926 private practice doctors in all specialties at more than 291 locations. In addition, there are over 129 neighborhood participating pharmacies, 17 participating hospitals and over 9 urgent care facilities.

OPM requires all FEHB Plans to provide certain information to their FEHB members. You may get information about us, our networks, our 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, 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 move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

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

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will decrease by 17.1% for Self Only or 16.4% for Self and Family.
- We clarified that the limit of 62 visits for physical and occupational therapies does not apply to cardiac rehabilitation services. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- Your copays under the Prescription Drug Benefits have changed to $5 generic; $15 brand name formulary; $40 brand name non-formulary. The mail-order copays are $10 generic; $30 brand name formulary; $80 brand name non-formulary.
- Prescriptions may be written by a participating or non-participating provider but must be filled at a participating pharmacy.
- We now cover certain intestinal transplants. (Section 5(b))
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- Our telephone area code has changed from 219 to 260 effective January 1, 2002.

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 contact us 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, 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 physicians

Plan providers are doctors and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan doctors 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 specialty care doctors is available among the Plan's more than 926 participating doctors. You do not need a referral from a primary care doctor to see a specialty care doctor 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.

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
- Durable Medical Equipment
- Growth Hormone Therapy
- Transplants
- Out-of-area Doctors
- Maternity
- Sleep Studies
- Sclerotherapy
- Feta Fibronectin
- Immune Globulin
- Penile Implants
- Reconstructive Surgeries
- Behavioral Health or Substance Abuse
- Non-Emergency Ambulance Transportation

Section 4. Your costs for covered services

You must share the cost 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 a copayment of $10 per office visit.

•Coinsurance — Coinsurance is the percentage of covered charges that you must pay for your care.

Example: You pay 40% of the charges for infertility treatment and 20% of hospital charges up to your out-of-pocket maximum.

•Deductible — We do not have a deductible.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

Medical Treatment

After your copayments and/or coinsurance total $500 per person or $1,500 per family enrollment in any calendar year, you do not have to pay any more for covered medical services. However, copayments for the following services do not count toward your medical out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs
- Durable Medical Equipment
- Prosthetic and Orthotic Devices
- Emergency Room Charge

Mental Health and Substance Abuse Treatment

After your copayments and/or coinsurance for Mental Health/Substance Abuse services total $500 per person or $1,500 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 out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs
- Emergency Room Charge

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 6 for how our benefits changed this year and page 55 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.

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

IMPORTANT

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.
- Plan doctors must provide or arrange your care.
- 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 out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
Professional services of physicians • In an urgent care center	$30 per visit
Professional services of physicians • During a hospital stay • In an extended care or skilled nursing facility • At home	Nothing
Not covered: • *Physical exams & immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel or examinations that are not necessary for medical reasons.* • *Professional services that are subject to exclusion*	*All Charges*

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing, if you receive these services during your office visit; otherwise $10 per office visit
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult test - Sigmoidoscopy, screening	$10 per office visit
Prostate Specific Antigen (PSA test)	$10 per office visit
Routine Pap Test: Note: The office visit is covered if pap is received on the same day; see Diagnosis and Treatment above. Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65, one every two consecutive calendar years	$10 per office visit
Routine immunizations in the doctor's office	$10 per office visit
Not covered: • *Physical exams & immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel or examinations that are not necessary for medical reasons.*	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit

Preventive care, children – Continued on next page.

Preventive care, children *(continued)*	**You pay**
• Well-child care charges for routine examinations, immunization and care • Examinations, such as: - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations	$10 per office visit
• Eye Exams for children through age 17 to determine the need for vision correction.	$20 per office visit
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel, or examinations that are not necessary for medical reasons.* • *Eye glasses, contacts, or related supplies.* • *Eye exercises*	*All charges*
Maternity care	
Routine Maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • Your Plan doctor will need to precertify your maternity services; see page 26 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c) *Hospital benefits* and Section 5(b) *Surgery benefits.*	$10 for initial office visit and nothing thereafter
• Labs, sonograms, fetal stress tests, etc., not included in the global fee.	$10 per office visit

Maternity care – Continued on next page.

Maternity care *(continued)*	**You pay**
Specialized obstetrical services such as: • Amniocentesis • Corionic Villi Sampling	$10 per office visit if performed in a doctor's office; otherwise, nothing
Not covered: Routine sonograms to determine sex.	*All charges*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization when performed in doctor's office • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
• Surgically implanted contraceptives (such as Norplant)	40% of charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: *-intravaginal insemination (IVI)* *-intracervical insemination (ICI)* *-intrauterine insemination (IUI)* • Fertility drugs Note: Fertility drugs are covered up to a 14-day supply of medicine, unless limited by drug manufacturer's packaging, per prescription or refill. We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. (See Section 5(f))	40% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *- in vitro fertilization* *- embryo transfer, gamete GIFT and zygote ZIFT* - zygote transfer • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23-24.	$10 per office visit when performed in the doctor's office; otherwise 20%
• Dialysis – Hemodialysis and peritoneal dialysis Note: Home intravenous (IV) therapy, Antibiotic therapy and Growth Hormone Therapy are covered as Home Health Services.	20% of charges
Not covered: Experimental, investigational or unproven services, treatments, supplies, drugs, devices, and procedures	*All charges*
Physical and occupational therapies	
• 62 visits per condition for the services of each of the following: - licensed physical therapists and - occupational therapists 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.	$10 per office or outpatient visit 20% during covered inpatient admission
Cardiac rehabilitation Note: Cardiac rehabilitation includes Phase I and Phase II treatments.	$10 per office visit Nothing per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehab therapy* • *Exercise programs* • *Developmental therapies*	*All charges*

Speech therapy	You pay
Up to 20 visits of speech therapy services per calendar year from a licensed speech therapist – Note: We cover habilitative or rehabilitative speech therapy.	$10 per office or outpatient visit 20% during covered inpatient admission
Not covered: • Developmental therapies • Behavior disorder • Stuttering/stammering • Tongue thrust	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing exam	$10 per visit
Not covered: Hearing aids and supplies	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
• One routine eye exam for members age 18 and older every twelve months. • Unlimited eye exams for children through age 17	$20 per visit
Not covered: • *Eyeglasses, contact lenses, or related supplies* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Replacements for lenses during the same calendar year the lenses were provided due to accidental ocular injury or intraocular surgery (such as cataracts)*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$10 per visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
• 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.	20% of charges
• Custom molded foot orthotics to be placed in shoes if ordered and/or provided by a Plan doctor. Note: Orthopedic and corrective shoes that are an integral part of a brace may be covered equipment if we approve them in advance.	20% of charges
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) dysfunction. Note: This benefit service is in combination with other TMJ services. See *Oral and maxillofacial surgery*.	40% of charges
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair or replacement of any non-medically necessary prosthetic devices*	*All charges*
Durable medical equipment (DME)	
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: • hospital beds; • standard wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. 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.	20% of charges

Durable medical equipment (DME) – Continued on next page.

Durable medical equipment (DME) *(continued)*	**You pay**
Not covered: • *Motorized wheel chairs, scooters, lifts for wheelchairs, or motor vehicles* • *Repair or replacement of any non-medically necessary DME* • *Batteries to operate DME* • *Common household articles such as: air conditioners, humidifiers, and air purifiers* • *Disposable or non-durable medical supplies such as: elastic bandages, elastic support, ostomy supplies and gauze*	*All charges*
Home health services	
• 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, Growth Hormone Therapy (GHT), and medications if provided by a Plan home health care agency. Note: Call 260/432-6690, Extension 11, for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Plan doctor will periodically review the program for continuing appropriateness and need. Note: Services such as physical and occupational therapy or durable medical equipment are subject to copayments or coinsurance. See also *Physical and occupational therapies, Speech therapy,* and *Durable medical equipment (DME).*	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*
Chiropractic	
No benefit	*All charges*

Alternative treatments	You pay
• No benefit.	*All charges*
Educational classes and programs	
Coverage is limited to diabetes self-management training, meeting these minimum requirements: • One visit after receiving a diagnosis of diabetes • One visit after receiving a diagnosis that: - represents a significant change in the patient's symptoms or condition; and - makes a change in self-management necessary. • One visit for refresher or re-education training.	$10 per office visit Nothing per outpatient or inpatient visit

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

IMPORTANT

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.
- Plan doctors must provide or arrange your care.
- 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 charge associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR DOCTOR MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- After you have met your out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity- a condition in which an individual weighs at least two (2) times the ideal weight for frame, age, height, and gender. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information such as: artificial knuckles and joints, pacemakers, insulin pump, defibrillator. • Voluntary sterilization • Treatment of burns	$10 per office visit

Surgical procedures - Continued on next page.

Surgical procedures *(continued)*	**You pay**
Note: We cover non-experimental, surgical treatment of morbid obesity that has persisted for at least five (5) years and you have received non-surgical treatment supervised by a doctor for at least 18 consecutive months that has been unsuccessful. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot. (See Foot care)*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: -the condition produced a major effect on the member's appearance, and -the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformaties, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes. Note: Generally, services done in the Plan doctor's office is a $10 per visit copayment; and if done in an outpatient facility, there would be a 20% copayment.	$10 per office visit
• All stages of breast reconstruction surgery following a mastectomy, such as: -surgery to produce a symmetrical appearance on the other breast; -treatment of any physical complications, such as lymphedemas; -breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit
• Treatment for services of Temporomandibular joint dysfunction (TMJ) Note: This benefit service is in combination with all TMJ services.	40% of charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Treatment of overbite or underbite, maxillary and mandibular osteotomies, dental x-rays, dental supplies, and appliances and all associated expenses* • *Orthodontic treatment or braces for teeth*	*All charges*
Organ/tissue transplants	
Limited to: • 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, eplithelial ovarian cancer, and testicular, mediastinal, retroperintoneal and ovarian germ cell tumors	$10.00 per office visit and Nothing for the actual transplant

Organ/tissue transplants - Continued on next page.

Organ/tissue transplants	You pay
• Intestinal transplant (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas 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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Note: Services outside an office visit, you pay nothing.	$10.00 per office visit and Nothing for the actual transplant
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs involving mechanical or animal origins* • *Transplants not listed as covered* • *Solid organ transplants performed as a treatment for cancer*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department or other facility • Skilled nursing facility	Nothing
• Office	$10 per office visit

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

IMPORTANT

Here are some important things to remember 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 and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., doctors, etc.) are covered in Sections 5(a) or (b).
- After you have met your out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.
- **YOUR DOCTOR MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	20% of charges

Inpatient hospital – Continued on next page.

Inpatient hospital *(continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms	20% of charges
• 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 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) *Accidental injury benefit.*	20% of charges
• Diagnostic laboratory tests, X-rays, and pathology services	Nothing
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefits/skilled nursing care facility benefits: • 60-days per calendar year for confinement in an approved inpatient transitional care unit when ordered by a par doctor. - bed, board and general nursing care (semi-private room) - drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the extended care/skilled nursing facility.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*

Hospice care	You pay
Inpatient and outpatient Hospice care Family counseling Note: These services are provided under the direction of a Plan doctor who certifies the patient to be terminally ill with six months or less to live.	Nothing
Not covered: • *Funeral arrangements* • P*astoral bereavement or legal counseling* • *Respite care* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Custodial care*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate Note: Non-emergency ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved in advance by PHP.	20% of charges

Section 5 (d). Emergency services/accidents

IMPORTANT

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.
- 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 out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.

IMPORTANT

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.

Emergency service/accident benefits begin on next page.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$30 per visit
• Emergency room care at a hospital, including doctors' services	$50 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency room care as an outpatient or inpatient at a hospital, including doctors' services	20% of charges
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. Note: Non-emergency or air ambulance transportation may be covered if recommended by a Plan doctor and is medically necessary and approved by PHP.	20% of charges

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

IMPORTANT

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:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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 out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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. Note: Drugs prescribed for your condition are covered under the Prescription drug benefits. (See Section 5(f))	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit Nothing if performed during an approved admission
• Diagnostic tests	$10 per office visit; otherwise 20% if billed by a hospital or other facility
• 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.	20% of charges

Mental health and substance abuse benefits -- Continued on next page.

Mental health and substance abuse benefits *(continued)*	**You pay**
Not covered: • *Services we have not authorized or approved* *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.*	*All charges*

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

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.

IMPORTANT

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 34-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.

  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.

Prescription drug benefits begin on next page.

Section 5 (f). Prescription drug benefits *(continued)*

- **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 limits.
- **When you 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, and multiple sclerosis medications.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan doctor and obtained from a Plan pharmacy: • Diabetic supplies • Drugs and medicines that by Federal law of the United States require a doctor's prescription for their purchase • Insulin (with a copayment applied to each vial) • Disposable needles and syringes needed to inject prescribed diabetes medications • Contraceptive drugs and devices Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable contraceptive drugs (such as Depo Provera), are covered under Section 5(a).	$5 generic per prescription unit $15 brand name formulary per prescription unit $40 brand name non-formulary per prescription unit
Mail-order: Up to a 90-day supply of **certain** Prescription Drugs that you use on an extended basis. Note: Nail fungus drugs and fertility drugs are not available through the mail-order program.	$10 generic per prescription unit $30 brand name formulary per prescription unit $80 brand name non-formulary per prescription unit
Norplant and other internally implanted time-released medications 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.	40% of charges per implantation
Fertility drugs Note: Up to a consecutive 14-day supply of medication, unless limited by drug manufacturer's packaging per prescription, order, or refill. Fertility drugs are not available through the mail-order program.	40% of charges

Covered medications and supplies – Continued on next page.

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication, including nicotine patches* • *Vitamins, nutrients and food supplements even if a Plan doctor prescribes or administers them* • *Nonprescription medicines*	*All Charges*

Section 5 (g). Special features

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

Section 5 (h). Dental benefits

IMPORTANT

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.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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 out-of-pocket maximum, you do not have to pay anything more for covered services. Certain services do not count toward your out-of-pocket maximum. See Section 4, Your out-of-pocket maximum, for more information.

IMPORTANT

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
Not covered: • *Injury to the teeth caused by eating, chewing, or biting.* • *Services provided after 12 months of the accident* • *Temporary prosthetics including but not limited to:* – *partial or full dentures or bridges or* – *replacement prosthesis* – *manipulative, corrective or cosmetic adjustments of the teeth* – *orthodontia services* • *Any other dental services*	*All charges*
Dental benefits	
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 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; or
- Services, drugs, or supplies you receive from a doctor or facility barred from the FEHB Program.

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 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 out-of-area care -- 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:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Physicians Health Plan of Northern Indiana, Inc., 8101 West Jefferson Boulevard, Fort Wayne, Indiana 46804-4163; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as Plan doctors' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E. Street, NW, Washington, D.C. 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as Plan doctors' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical doctors, 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.

6 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 Benefits Contracts Division 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 are covered or a family member is covered 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.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and 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.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan (Part A or Part B)

The Original Medical 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, like prescription drugs.

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.

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** 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 either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB or	✓	
b) The position is not excluded from FEHB		✓
(Ask your employing office which of these applies to you.)		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability,		
a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Please note, if your Plan doctor does not participate in Medicare, you will have to file a claim with Medicare

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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, 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 waive some costs when you have the Original Medicare Plan-- When Original Medicare is the primary payer, we may waive some copayments and coinsurance, for services that Medicare covers. However, we will not waive copayments, coinsurance, or deductibles for services that Medicare does not cover and we do. Please contact us for specific information.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care 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 manage care plan does not cover. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care Plan's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

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.

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 all of the 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.

Copayment

A copayment is an amount of money that you pay directly to the provider when you receive covered services. A copayment may be either a fixed dollar amount or a percentage of eligible expenses.

Covered services

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

Custodial care

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

- Do not seek to cure;
- Are provided when the medical condition of the Member is not changing;
- Do not require administration by skilled, licensed medical personnel because a non-professionally qualified person can be trained to perform them.

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 *all* of the following:

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

Plan allowance

Plan allowance is the amount we use to determine our payment and your copayment 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

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:

- 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 do not 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.

When benefits and premiums start

The benefits in this brochure are effective on 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. 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.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

• 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. But, you may be eligible for your own FEHB coverage under the spouse equity law. 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.

•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 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 pamphet 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.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the *"Not covered"* blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

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

Notes

Notes

Notes

Summary of benefits for Physicians Health Plan of Northern Indiana – 2002

- **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.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	12
Services provided by a hospital: • Inpatient..... • Outpatient.....	20% of the first $2,500 up to the out-of-pocket maximum of $500 per person or $1,500 per family	25 26
Emergency benefits: • In-area ..... • Out-of-area	$50 per Plan hospital emergency room visit or $30 per Plan urgent care center visit 20% of the first $2,500 up to the out-of-pocket maximum	28
Mental health and substance abuse treatment.....	Regular cost sharing.	30
Prescription drugs Up to a 34 day supply ..... Mail-order drugs Up to a 90 day supply of maintenance medication	$5 generic/ $15 brand name formulary/ $40 brand name non-formulary per prescription unit or refill $10 generic/$30 brand name formulary/$80 brand name non-formulary per prescription unit or refill	32
Dental Care..... No benefit	All charges	36
Vision Care..... Limited to one annual eye refraction for members 18 and over	$20	17
Protection against catastrophic costs (your out-of-pocket maximums)..... Some costs do not count toward this protection. The out-of-pocket maximums are separate for medical and mental health/substance abuse services.	Nothing after $500/Self Only or $1,500 Self and Family enrollment per year	10

2002 Rate Information for
Physicians Health Plan of Northern Indiana, Inc.

Non-Postal rates apply to most non-Postal enrollees. 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 special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and 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. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	DQ1	$ 91.76	$30.58	$198.80	$ 66.27	$108.58	$ 13.76
Self and Family	DQ2	$206.18	$68.73	$446.73	$148.91	$243.98	$ 30.93