



Indigo Individual™ Benefit Plans ***Offering Copay and HSA Compatible Plans***

Use this guide to select the Indigo Individual plan that best fits your needs. This side-by-side comparison gives you a look at all of our benefit plans. Whether you are looking for a more traditional Copay Plan, the flexibility of an HSA Compatible Plan, or the choice of adding out-of-network benefits, there is an Indigo plan for you.

Our **Copay Plans** are designed much like traditional group plans with a copayment structure for routine health services and pharmacy coverage. Copay Plans typically have a higher monthly premium and lower deductible amounts than the HSA Compatible Plans.

HSA Compatible Plans allow you to have more control over how your healthcare dollars are spent. By selecting a higher deductible plan, you can save money with lower monthly premiums. You also have

the option of combining a Health Savings Account with the High Deductible Plan to save for future medical expensed on a tax-free basis.

Several HSA Plans also offer the option of having Embedded Deductibles. **Embedded Deductible** means, when an individual is enrolled in a family policy, the maximum deductible per individual is equal to the single deductible.

With a **Non-embedded Deductible** family policy, only the family deductible applies.

For more information about Indigo Individual plans, please contact Nancy Blake, Senior Account Executive at (260) 432-6690, ext. 365; 1-800-982-6257, ext. 365; or via email at nblake@phpni.com.



The insurance your health deserves.

Covered Benefits	Copay Plans	Copay Choice Plans	
Individual Annual Maximum	\$1,250,000	\$1,250,000	
Pre-existing Period for Members <i>Age 19 and older</i>	12 months	12 months	
		In-Network	Out-of-Network
CHOOSE YOUR COVERAGE LEVEL:			
Deductible (Single/Family)	▶ \$1,000/\$2,000 ▶ \$3,500/\$7,000	▶ \$2,500/\$5,000	\$5,000/\$10,000
Out-of-Pocket Max (Single/Family)	\$3,000/\$6,000 \$7,000/\$14,000	\$5,000/\$10,000	\$10,000/\$20,000
	▶ \$1,500/\$3,000 ▶ \$5,000/\$10,000	▶ \$3,500/\$7,000	\$7,000/\$14,000
	\$3,500/\$7,000 \$8,500/\$17,000	\$7,000/\$14,000	\$14,000/\$28,000
	▶ \$2,500/\$5,000	▶ \$5,000/\$10,000	\$10,000/\$20,000
	\$5,000/\$10,000	\$8,500/\$17,000	\$17,000/\$34,000
Preventive Services <i>Services rated 'A' or 'B' by the U.S. Preventive Services Task Force, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Preventive care and screenings for women and children as recommended by the Health Resources and Services Administration. For a complete list, please visit our website.</i>	No charge Deductible waived	No charge Deductible waived	50%
Doctor's Office Visit <i>Illness, injury, or sickness</i>	\$30 each for 2 visits per covered person, then 30%*	\$30 each for 2 visits per covered person, then 30%*	50%*
Diagnostic <i>Routine radiology and lab services (ex. chest x-ray, MRI, blood and urine tests).</i>	30%*	30%*	50%*
Outpatient Services	30%*	30%*	50%*
Inpatient Services	30%*	30%*	50%*
Hospital Emergency Room	\$200 per visit plus 30%* of the remaining charges	\$200 per visit plus 30%* of the remaining charges	
Urgent Care Center	\$40 per visit plus 30%* of remaining charges	\$40 per visit plus 30%* of remaining charges	
Ambulance Service	30%*	30%*	
Other Covered Services			
Skeletal Manipulations			Skeletal Manipulations: \$25 max benefit; 30-day limit* <i>(coinsurance applies)</i>
Home Health Care <i>60 day plan year limit</i>			
Hospice Care and Services <i>180 consecutive days per lifetime</i>	Skeletal Manipulations: \$25 max benefit; 30-day limit*	Skeletal Manipulations: \$25 max benefit; 30-day limit*	Hospice: Not Covered.
Inpatient Transitional Care Unit <i>30 day plan year limit</i>			
Durable Medical Equipment, Prosthetics, Orthotic Appliances, and Ostomy Supplies	30%*	30%*	Home Health Care, Inpatient TCU, Durable Medical Equipment, Transplant and Rescue: 50%
Transplant and Rescue Procedures			<i>(Limited benefits, see Schedule of Benefits for details)</i>
<i>Refer to the Schedule of Benefits for a complete list of covered services.</i>			
Individual Outpatient Prescription Drug Deductible	\$500 <i>(Applies to all drug categories listed below except for Generics.)</i>	\$500 <i>(Applies to all drug categories listed below except for Generics.)</i>	
Calendar Year Maximum	-	-	
Prescription Drugs <i>Up to 30 day supply, including diabetic supplies, per prescription or refill. Two over-the-counter vials of insulin. One-unit limit for inhaler aid devices such as aerochambers, inspirease, etc.</i>	Generic Drug: \$10 Formulary Brand: \$30 Non-formulary Brand: 50% <i>with a minimum of \$50 up to a maximum of \$100</i>	Generic Drug: \$10 Formulary Brand: \$30 Non-formulary Brand: 50% <i>with a minimum of \$50 up to a maximum of \$100</i>	50% <i>with a minimum of \$50</i>
Specialty Drugs <i>Up to 30 day supply.</i>	50% <i>with a minimum of \$200 up to a maximum of \$400</i>	50% <i>with a minimum of \$200 up to a maximum of \$400</i>	50% <i>with a minimum of \$200 (Office administered only)</i>
Mail Order Prescription Drugs <i>Up to 90 day supply, including diabetic supplies, per prescription or refill. Six over-the-counter vials of insulin.</i>	Generic Drug: \$30 Formulary Brand: \$90 Non-formulary Brand: 50% <i>with a minimum of \$150 up to a maximum of \$300</i>	Generic Drug: \$30 Formulary Brand: \$90 Non-formulary Brand: 50% <i>with a minimum of \$150 up to a maximum of \$300</i>	Not Covered

*Services are subject to the Medical Deductible and apply toward the Medical Out-of-Pocket limit.

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