



PHP Member Handbook

Information to help you and your family make the most of your PHP benefit plan

Indigo Individual™



PHP

The insurance your health deserves.

This handbook is a general summary of the benefits and programs offered by PHP. Please refer to your Certificate of Coverage or Contract for specific details about your plan.



The insurance your health deserves.

How to Contact Us

We are readily available to support you when you need healthcare assistance. Getting your questions answered is easy—you can reach us by phone, email, our Web site, or visit us in person. Questions about benefits, eligibility, claims payment, prior authorization, or the participation status of doctors, hospitals, or other facilities can be addressed in person by our Customer Service Department Monday through Friday, 8:00 am to 5:00 pm.

You can also browse our Web site medical library for health-related information. If you do not find an answer to your coverage questions, do not hesitate to contact us. We are here to help you!

Phone Numbers

Voice: (260) 432-6690, ext. 11
Toll-free: 1-800-982-6257, ext. 11
Hearing Impaired: (260) 459-2600
Fax: (260) 432-0493

Address

Attention: Individual Product
PHP
8101 West Jefferson Blvd.
Fort Wayne, IN 46804-4163

Web site

www.phpni.com

Email

custsvc@phpni.com

To help us in our efforts to provide excellent service, be sure to include your name and birth year when using email.

Payment Remittance Address

PHP
PO Box 10930
Fort Wayne, IN 46854-0930

How to file a claim

If you receive services from a provider in the PHP network, they will submit claims on your behalf. However, if you receive services from a provider outside of the PHP network, you are responsible for submitting claims to PHP within 90 days of the service.

Your claim should include the following information:

- **Your name and address**
- **Patient's name and birth year**
- **Name and address of the provider of services**
- **Diagnosis from the provider**

Submit claims to:

Attention: Individual Product
PHP
PO Box 2359
Fort Wayne, IN 46801-2359

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You can also browse our Web site medical library for health-related information. If you do not find an answer to your coverage questions, do not hesitate to contact us. We are here to help you!

Keep Us Updated

Let us know when you make a change in your family status. This will enable us to ensure that we can contact you as well as keep our records updated. Please contact our Customer Service Department when you experience any of the following changes:

- Address or phone number
- Additional insurance coverage
- Change in employment
- Change in banking arrangements
- Marriage or divorce
- Death in the family
- Birth or adoption

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custsvc@phpni.com

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New Sales and Broker Information

sales@phpni.com

If You Need Translation Services

How do I obtain information if I speak another language?

In our efforts to ensure that all of our members have the information they need to obtain quality healthcare, we have the ability to interpret over 140 different languages for non-English speaking members, with the assistance of AT&T Language Line Services. Our Customer Service Department will coordinate with a translator to get immediate answers to your questions. Call or write to us for more information.

¿Como puedo obtener información si hablo otro idioma?

En nuestros esfuerzos de asegurar que todos nuestros miembros reciban la información necesaria para obtener atención médica de calidad, ofrecemos servicios de interpretación para más de 140 lenguajes diversos por medio de la Línea de Lenguajes de AT&T. Nuestro departamento de Servicios al Cliente coordinará con un traductor para conseguir respuestas inmediatas a sus preguntas. Llámenos o escribanos para más información.



Introduction

We are completely dedicated to the health and well-being of the people of Northern Indiana. As a proud member of the community, we are devoted to helping and serving you, our neighbors. We strive to provide the best service and pledge to take care of the lives we touch each and every day.

As healthcare costs soar and we try to manage these costs, more of us are depending upon health education and wellness programs to prevent illnesses. You can count on us to help you learn about new ways to be healthy, as well as how to use our special programs to create a more proactive healthy lifestyle for you and your family. Additionally, we are always keeping current with new technologies so that you have the most up-to-date resources and treatments to keep you well.

Who We Are

You may wonder who we are. Most insurance companies have a national identity with a focus on driving profits for themselves. But we are a local, not-for-profit health insurance company that is governed by area doctors and business representatives. Being not-for-profit means that we focus on working for a healthy community - not paying shareholders. In 1983, area physicians formed PHP to provide an alternative to managed care organizations that would direct standards of care and healthcare costs from outside Northern Indiana. We make our business decisions right here at home where we all live and work. Trust that our team is committed to providing you with the highest quality and most affordable healthcare.



What Does this Mean for You and Your Family?

It means that your care is in your hands and those of your doctors. With PHP you have:

- **The freedom of choice**
- **Improved quality of care**
- **The potential for reduced healthcare costs**

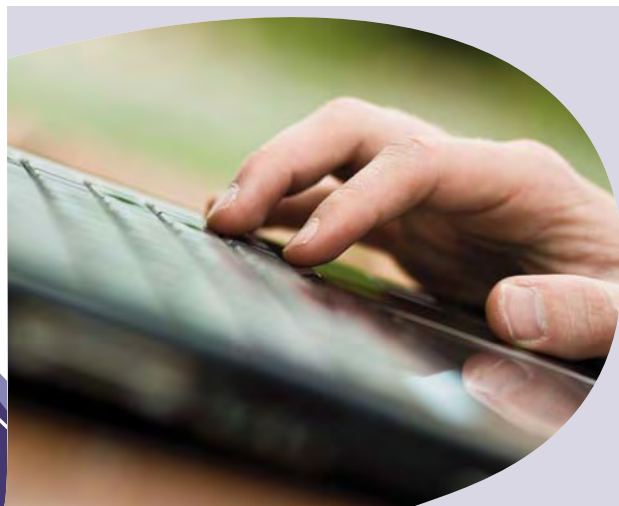
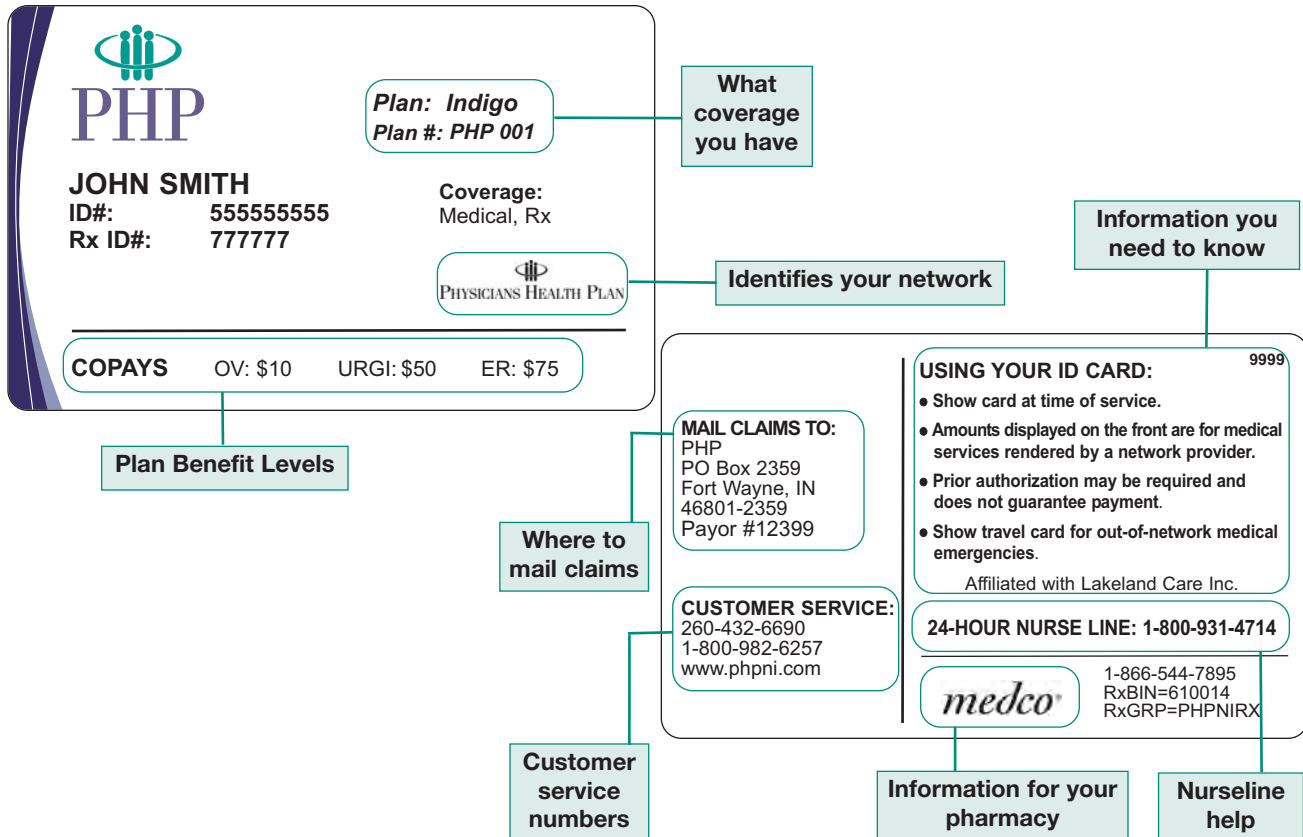
We care about you and your family because we live in the same community and have families of our own. We live, work, and volunteer our services alongside our members and participating doctors.

By striving to improve the way we achieve healthy lifestyles, offering wellness programs and incentives, and providing a strong team of area physicians and facilities to take care of you, we are advocates for a healthy Northern Indiana. We work hard at building long-term relationships with area healthcare providers in order to benefit you. We will always work hard to team up with the doctors who provide the best care to their patients. **We put our members and Northern Indiana first!**

Understanding Your Member ID Card

Your member ID card is your passport to receiving the highest quality healthcare at the most reasonable out-of-pocket cost. Simply present your ID card to a participating doctor or facility at the time

services are rendered. Please refer to your Schedule of Benefits or call our Customer Service Department for specific information about your benefits.



Locating Your Certificate of Coverage

Your Certificate of Coverage outlines the full range of benefits covered under your plan and is available online to view or print on demand. As part of our ongoing commitment to reduce paper use and increase recycling efforts, we do not automatically print and mail these documents. Log-on as a member and click the *My Contracts* button found on www.phpni.com. Follow the easy to use instructions – it's that simple! Should you need a printed copy, please contact our Customer Service Department.

Billing Information

Payment Options

- Monthly Electronic Funds Transfer (EFT)
- Quarterly Direct Billing
- Credit Card (*monthly or quarterly billing*)
- List Billing (*for employers only, with a minimum of two approved contracts in order to establish and maintain*)

You are responsible to ensure that all banking information is appropriately completed on the application for the initial set-up of the Monthly Electronic Funds Transfer or credit card payment. The first month's premium will be charged upon the application's acceptance. **Billing dates are based on your plan effective date. For example, if your plan became effective on the 1st of the month, your bill will be due the 1st of every month. This cannot be changed.** Checks and/or money orders for quarterly direct billing should be made payable to PHP, and dated the same date the application is signed. Agent or agency checks will not be accepted.

Monthly Electronic Funds Transfer (EFT)

Once EFT is set up, we will withdraw premium from the designated checking or savings account on the date payment is due. Changes to banking information must be received no later than the 20 days before the date payment is due.

Quarterly Direct Billing

(Monthly direct billing is not available)

Quarterly direct billing premium notices are mailed prior to the due date. Even if you have not received a bill from Us, You are still obligated to pay, at a minimum, the prior amount due. A service charge in the maximum allowable amount under law may be charged for any non-sufficient payment method used to pay the Premium.

Credit Card/Debit

Payment by Visa, MasterCard, or Discover is available on a monthly or quarterly basis.

List Billing

(For employers only, with a minimum of two approved contracts)

List Bill Accounts allows an employer to facilitate

the payment of contract premiums for individual medical coverage purchased by their employees. The employer must complete a List Bill Agreement form in order to establish an account. All contracts must be effective on the first of the month.

- List Bill Accounts are billed prior to the bill's due date to the EMPLOYER of the contract holders on a combined bill that is due and payable on or before the due date.
- The employer may submit one check to cover all of the employees' contract premiums that are due.
- **IMPORTANT!** If your employer fails to forward your premium, your policy may lapse.

A List Bill cannot be offered if:

- The employer directly contributes towards the employee's contract premiums
- Salary adjustments are made to offset the insurance premium expense
- Deductions are made from the employee's gross income for purposes of reimbursement
- The employer treats the plan as a trade for business expense or provides other healthcare coverage

Grace Period

Following payment of the initial premium, a grace period of 31 days will be granted for the payment of any premium. This grace period shall not extend beyond the date the contract terminates. During the grace period the contract shall continue in force. Any claims incurred and submitted during the grace period may not be considered for payment until premium is received. If premium is not received, within the grace period, claims incurred during the grace period will be denied and the contract will automatically terminate to the last paid date of coverage.

Reinstatements

Unpaid policies will lapse after the grace period has expired. All requests for reinstatement must be accompanied by a formal application and all eligibility requirements must be met. If approved by underwriting, a new policy will be issued with a new effective date and new benefit waiting periods.

Applying for Benefit Changes

The Individual Enrollment and Change Application can be used to request changes to a policy. Any changes in coverage or addition of dependents will be subject to the next available effective date. See the table below to determine which section(s) of the form we need completed to process your request.

Please note:

- Policy downgrade requests can be made at any time
- Policy upgrades can be requested once per each 12-month period within 30 days of the policy anniversary date
- Change of coverage requests must be submitted by email, fax or mail – telephone requests will not be considered.

Change Requested	Requirements
Personal information such as: <ul style="list-style-type: none"> • Address • Name • Telephone, etc 	<ul style="list-style-type: none"> • Request in writing signed by the member <p>OR</p> <ul style="list-style-type: none"> • Section 1 and Section 9 of the enrollment form
Downgrades (see table below) such as: <ul style="list-style-type: none"> • Decreasing benefits • Increasing deductibles/out-of-pocket max 	<ul style="list-style-type: none"> • No underwriting required • Section 1, Section 2, and Section 9 of the Enrollment Form
Upgrades (see table below) such as: <ul style="list-style-type: none"> • Increasing benefits • Decreasing deductibles/out-of-pocket max 	<ul style="list-style-type: none"> • Requires full underwriting. The entire Enrollment Form must be completed. • Follow new application submission procedures
Add dependents <i>(Does not apply to newborns, adopted children or children placed for the purpose of adoption if requested within 31 days from birth, adoption or placement.)</i>	<ul style="list-style-type: none"> • Requires full underwriting. The entire Enrollment Form must be completed. <ul style="list-style-type: none"> ○ The health history sections of the application are only required for new applicants. ○ Medical history of existing members is not needed. ○ The application must be signed by the primary applicant and all new applicants over the age of 18.



How Do I Find a Participating Provider?

Finding a PHP participating healthcare provider is easy, just refer to our provider directory or give us a call. **The provider directory is available on our Web site at www.phpni.com under the Member portal.** A printed version is available upon request only. The directory lists participating doctors by city, and then by their specialty to help you locate the provider nearest to you. Please be aware that this information is updated regularly but a doctor's status sometimes changes between updates. To be certain a doctor is participating, ask the office staff prior to receiving care, or call the PHP Customer Service Department. Always show your ID card at each visit.

Do I need to choose a Primary Care Physician (PCP)?

A Primary Care Physician (PCP) is not required. Our network is open access. Therefore, no referral is needed to see participating specialists or to

change doctors as long as they are in our plan. We do recommend that you choose a physician such as a Family and General Practice, Internal Medicine, Pediatrics, or OB/GYN to oversee coordination of your healthcare for the best overall quality care.

What if I need medical care that is not available from a doctor participating in the network?

A referral to an out-of-network doctor may be obtained if a uniquely specialized procedure is medically necessary and not performed by any participating doctors. This process must be requested by your participating doctor and approved in writing by PHP, prior to receiving the services. **For more information on Out-of-Network Referrals, please refer to that section of the handbook or call our Customer Service Department.**



Provider Directory Online

Log-on as a member to our site at www.phpni.com and select the Provider Directory option under the "Provider Network" button to use the provider directory online.

You can search by:

- Location
- Proximity
- Name
- Specialty
- Gender

Getting the Most From Your Doctor Visit

When it comes to managing your health and that of your loved ones, you will have an improved outcome when you have a good interaction with your healthcare provider. The following tips and checklist can help you and your doctor work as a team to improve your health together.

Tip 1: Take personal responsibility for your health

Taking an active role in your healthcare can help you get the best care possible from your doctor. In general, people who work with their health professionals to make health decisions are happier with the care they receive and the results they achieve.

Tip 2: Keep good records

Having a readily available personal record of your current health status, medications, and past medical history can help you handle emergencies as well as provide answers to health-related questions.

Tip 3: Know your numbers

Know your total cholesterol levels or the breakdown of the good and bad cholesterol. Know your blood pressure readings and record them. Keep track of your weight and height. Always obtain a copy of test results and write down your doctor's explanations of any numbers or other data that you do not understand. Keep all of this information in a file at home with the rest of your health records.

Tip 4: Practice medical self-care

Keep track of your symptoms and signs. For example, you will want to ask yourself the following questions:

- When did your symptoms or signs of illness begin?
- How have they progressed?
- What symptoms are you presently experiencing?

Tip 5: Communicate openly with your doctor

Ask questions and give honest answers to any questions your doctor asks. If you do not ask questions, your doctor will think that you understand everything he or she has told you.

- Ask a question every time you do not understand something.
- If you have questions before the appointment, write them down.
- Tell your doctor if you need more time to talk about something. If the doctor is not available to help, you should be able to talk to a physician's assistant or a nurse. If no one else is available, see if you can schedule another appointment to continue your discussion.

Tip 6: Take notes

Take notes during your appointment. Ask the doctor for clarification if a term is not familiar to you. Ask the doctor for proper spelling and meanings as well. Taking written information home with you can help you remember what was said, as well as how to follow instructions that the doctor gave to you.

Tip 7: Follow up with your doctor

Follow any instructions from your doctor (e.g., taking medicine, scheduling a test or an appointment with a specialist), even after you start to feel better. If you are confused or if you have forgotten some information, it is okay to contact your doctor. Some common reasons you may need to call your doctor include the following examples:

- When you have any questions after the appointment. Call the office and ask to leave a message with the doctor or to speak with a nurse.
- When you start to feel worse or have problems with your medication.
- When you have had tests but have not received the results.



Ask-the-Doctor Checklist

Use the following guidelines to organize your thoughts and questions. Before you go to your doctor's appointment, take a few minutes to prepare for your visit. Also, remember to bring any relevant information with you to the appointment.

Step 1: Prepare for your visit

Gather any x-rays, test results or medical records that you need to take with you to the appointment. Bring a list of any medications that you are currently taking. Include information such as:

- When and how often you take the medicine, as well as the strength of the medicine (for example, do you take 150 mg or 200 mg?)
- Any side effects you may have from your medicine(s)
- Any vitamins or supplements you take

Step 2: State the main problem

At the beginning of your doctor's visit, state your main problem first. Describe your symptoms and explain when those symptoms started. Be sure to include any past experiences with the same symptoms. You should inform your doctor if anyone else at home or work has these symptoms. State any changes in your life. Be sure to include things like stress, medications, food, exercise, etc.

Step 3: Ask questions about treatments

When the doctor suggests medications, tests, and/or treatments, you may want to ask the following questions:

- What is the medication, test and/or treatment's name and why is it needed?
- Are there any alternatives?
- What are the risks or side effects?
- What if I do nothing?
- How do I take this?
- How do I prepare?
- How long before I see results?

Step 4: Ask concluding questions

As the visit comes to a close, consider asking the following questions:

- Am I to return for another visit?
- Am I to phone in for test results?
- What danger signs should I look for?
- What else do I need to know?

Step 5: Evaluate your progress

Ask yourself: are you getting better or worse?



Out-of-Network Referrals

If your PHP physician determines that you need to be referred to a specialist that is out of our provider network, your PHP physician must complete and forward a referral request form and documentation supporting the request prior to the out-of-network services. We will review the request and determine if the out-of-network services are authorized.

Should these services be authorized, an authorization letter will be sent to you, your PHP physician, and the physician you were referred to. You need to have the authorization letter from us prior to seeing an out-of-network provider or you may be financially responsible for these services.

Feel free to contact PHP's Medical Management Department with any questions regarding out-of-network plan referrals, at (260) 432-6690, Extension 12 or 1-800-982-6257, Extension 12.

Out-of-Area Emergency Care

An emergency allows coverage for services that a reasonable person would consider dangerous to the patient's life or health. If a life-threatening medical condition occurs, call 911 or your local emergency service. If a non-life-threatening emergency occurs, contact your doctor for direction.

What should I do in case of an emergency while outside the service area?

If you are traveling and an emergency occurs, contact the nearest emergency service. It is a good idea to discuss with your doctor what to do in the event of an urgent medical situation before it happens. Being prepared and having information about existing healthcare conditions and any medications currently being taken is important. This information will assist the emergency healthcare providers in their choice of treatment options and can improve your likelihood for a healthy outcome.



Medical Treatment Consent Forms

Are you preparing for some time away from the kids? With children, emergencies pop up at the most unexpected times. Be prepared by leaving a "Medical Treatment Consent Form" with your child's caregiver. This form is used in case of an emergency when a parent or legal guardian cannot be reached. If the person responsible for the minor presents this form, he or she has the authority to provide consent for the medical treatment of that child.

The Medical Treatment Consent form can be found on the PHP website by logging onto the Member Portal and clicking the "Forms" button to download a copy (Acrobat Reader required). Having this form prepared could save your child's life.

Medical Treatment Consent Form

Did you know that in your absence, no one caring for your children can authorize their medical care without your written permission? If you leave your child with a babysitter while you are working or traveling, complete this form, have it witnessed and leave it with your caregiver. This will ensure that in an emergency, your child will receive prompt, necessary medical care even if you are not there to give consent.

Consent For Medical Treatment

In case of emergency, I authorize (full name) _____
of (full address) _____
to give consent during my absence for my child(ren) listed below to be hospitalized, have surgery or receive other necessary healthcare:

Child's Information

Child's full name _____ Date of birth _____

Child's physician/phone number _____

Important medical history (chronic conditions, allergies, reactions, etc.) _____

Child's full name _____ Date of birth _____

Child's physician/phone number _____

Important medical history (chronic conditions, allergies, reactions, etc.) _____

Parent(s)/Guardian(s) Information

Name _____ Phone number _____

Address _____

Signature _____ Date _____

Witnessed by:

Name _____

Signature _____ Date _____



College-Bound Dependents

PHP realizes that not all dependent college students attend college in our service area. That is why PHP provides coverage for urgent care services and supplies, as well as coverage for medical emergencies. A medical emergency is defined as an unanticipated need for services and supplies once the student has left our service area. If an anticipated need occurs, your college student must receive care in the designated service area, such as a follow-up appointment for a cast that was acquired prior to leaving the service area. Your college student is NOT covered outside of the service area for routine care.

If you have questions or concerns about your dependent's coverage while away at school, contact our Customer Service Department for details specific to your contract.

Travel Cards

We offer an Emergency Travel Card Program. The travel card can be used when a medical emergency occurs while away from home. The card can help locate a healthcare provider and is designed to save money on the cost of care.

When you see a provider, please present your travel card along with your PHP card at the time of service. The decision to pay a claim is made only after services have been rendered and the claim has been filed with information sufficient to make a benefit payment decision.

TRAVEL CARD
Emergency healthcare coverage

When a medical emergency occurs while traveling away from home, present this card along with your traditional ID card. Prior authorization may be required for some services.

To Locate Providers: Use NHBC group ID #: NATACC269
888-621-7900 <http://www.phpni.com>

This card does not prove participation nor guarantee coverage. For verification of benefits, please contact customer service as listed on back of your traditional ID card.

Maternity Benefits

We will cover maternity services when the additional benefit is purchased. The optional maternity benefits become active after a 12-month waiting period and include inpatient, surgical, medical, and professional services for a hospital stay.

Pregnancy complications are not paid under maternity benefits, but paid the same as any other illness. Please call Customer Service for details.

Subrogation

Insurance companies research claims that may be work- or accident-related to determine if another party is responsible for payment. This process is called subrogation.

How does it work?

Before paying a claim that is possibly the responsibility of a third-party (such as workers compensation, auto insurance, or property/liability insurance), PHP will investigate the claim. Information is gathered from the member by telephone or by letter. Once responsibility is established, PHP will coordinate any payments with the third-party.

Do all insurance companies do this?

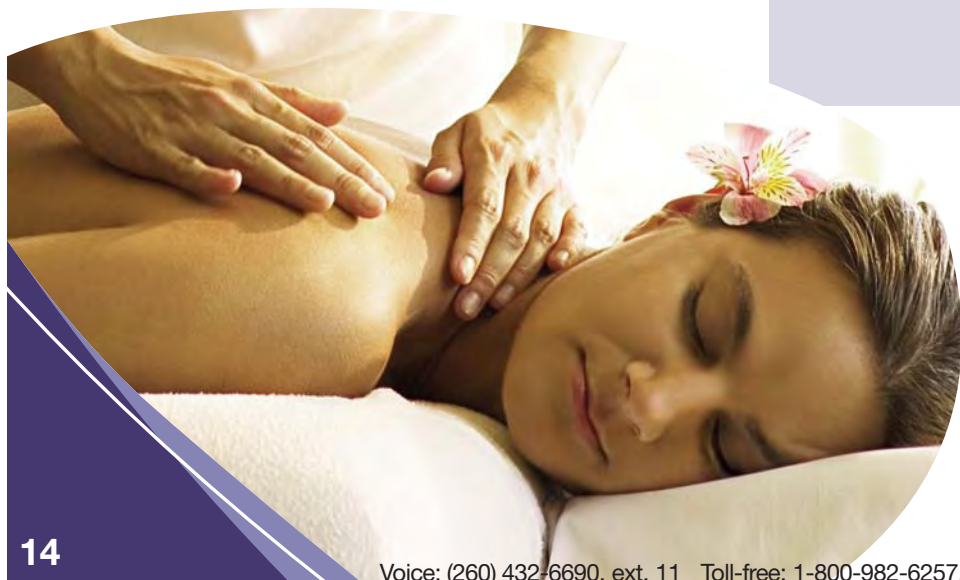
Subrogation is a standard process and protects the right to recover expenses in situations where the damages appear to have been caused by the negligence or fault of third parties. Your health plan documents contain subrogation provisions which give the right to subrogate against third parties and the right to reimbursement where there has already been a recovery from a third party.

What Insurance Does Not Cover

Like every other insurance policy, there are limitations and excluded services in your health insurance policy. The following is a partial list of health services that are not covered:

- Treatment for behavioral and mental health
- Treatment for chemical dependency
- TMJ or jaw surgery
- Alternative or complementary medicine
- Cosmetic or services not medically necessary
- Routine foot care including orthopedic shoes
- Experimental or investigational procedures
- Injuries or illness as a result of participation in an illegal activity, driving under the influence of an intoxicant, or an act of war
- Bariatric surgery
- Normal pregnancy or child birth except as mandated by law or provided for by the optional maternity benefit
- Dental care
- Hearing aids
- Conditions that are pre-existing or excluded by a waiver
- Sexual dysfunction
- Mail order prescription drugs
- Self-inflicted injuries or illness
- Injuries or illnesses covered by workers' compensation or as a result of a third-party liability

Always be sure to read and understand your coverage limitations before undergoing treatment. If you have any questions about whether a particular service is covered under your policy, please contact our Customer Service Department.



Pre-existing Conditions

All of our individual and family policies have a 12-month exclusion period for pre-existing conditions for individuals age 19 and older. Under the contract, pre-existing conditions are defined as condition(s):

- that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment; or,
- for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months preceding the policy effective date.

All of our plans have a 12-month waiting period for pre-existing conditions.

Waivers

We believe that the cost of covering expenses of someone with minimal healthcare needs should not be unfairly offset by someone whose health can be predicted to require costly care. To balance the risk, we have the option of placing applicants in different rating tiers and/or offering enrollment with a policy

exclusion waiver. The waiver allows us to provide coverage in certain instances where other carriers would decline coverage altogether.

A waiver is a surrender of the right to benefits for a certain period of time for a specified condition known to exist prior to or at the time of application, and any future complications that may arise.

Waivers can be applied for various reasons, including:

- Conditions with somewhat routine or predictable treatment methods
- Certain medical conditions that present potentially costly medical treatment that will exceed premiums and/or deductible amounts.

Waiver durations vary depending on the overall level of risk associated with the condition. No more than two waivers may be applied to any one PHP member. Waivers automatically terminate from the policy at the end of their specified duration and at that time rights to benefits would become effective.

Misrepresentations

A misrepresentation is omitted, incomplete, or false information during the application process that, if known by us, may have caused us to not issue a policy or issue a policy with restrictive terms or with additional premium. You, as the insured, have a duty to make full and complete disclosure of all relevant information when completing an application to ensure that the Underwriting Department is given all the information necessary to make the best decision.

We perform routine claim reviews when claims are submitted with certain diagnoses that indicate a medical condition may have been present prior to the policy's effective date (i.e. pre-existing) to protect against risks created by misrepresentations. If we discover misrepresentation, we may do one of the following:

- take no action and process the claim according to policy terms;

- issue a retroactive rate adjustment or waiver and process the claim according to policy terms;
- rescind the policy.

A rescission renders the policy unenforceable as of the policy's effective date--no benefits are payable. We may contest potential policy misrepresentations up to two years from the policy's effective date, with the exception of fraudulent misrepresentations which can cause the policy to be void even after two years.

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996. HIPAA has established many requirements for health plans and issuers of health coverage. Employers and insurers are obligated to comply with HIPAA.

HIPAA contains two main provisions:

- A. Portability
- B. Administrative Simplification

The Portability provisions are designed to:

- A. Improve the portability of health coverage for people who are changing jobs
- B. Make it easier to add family members to an employee's coverage
- C. Permit mid-year special enrollments
- D. Provide a HIPAA Certificate to each covered individual who loses coverage
- E. Prohibit discrimination based on health status

The three major provisions of Administrative Simplification are:

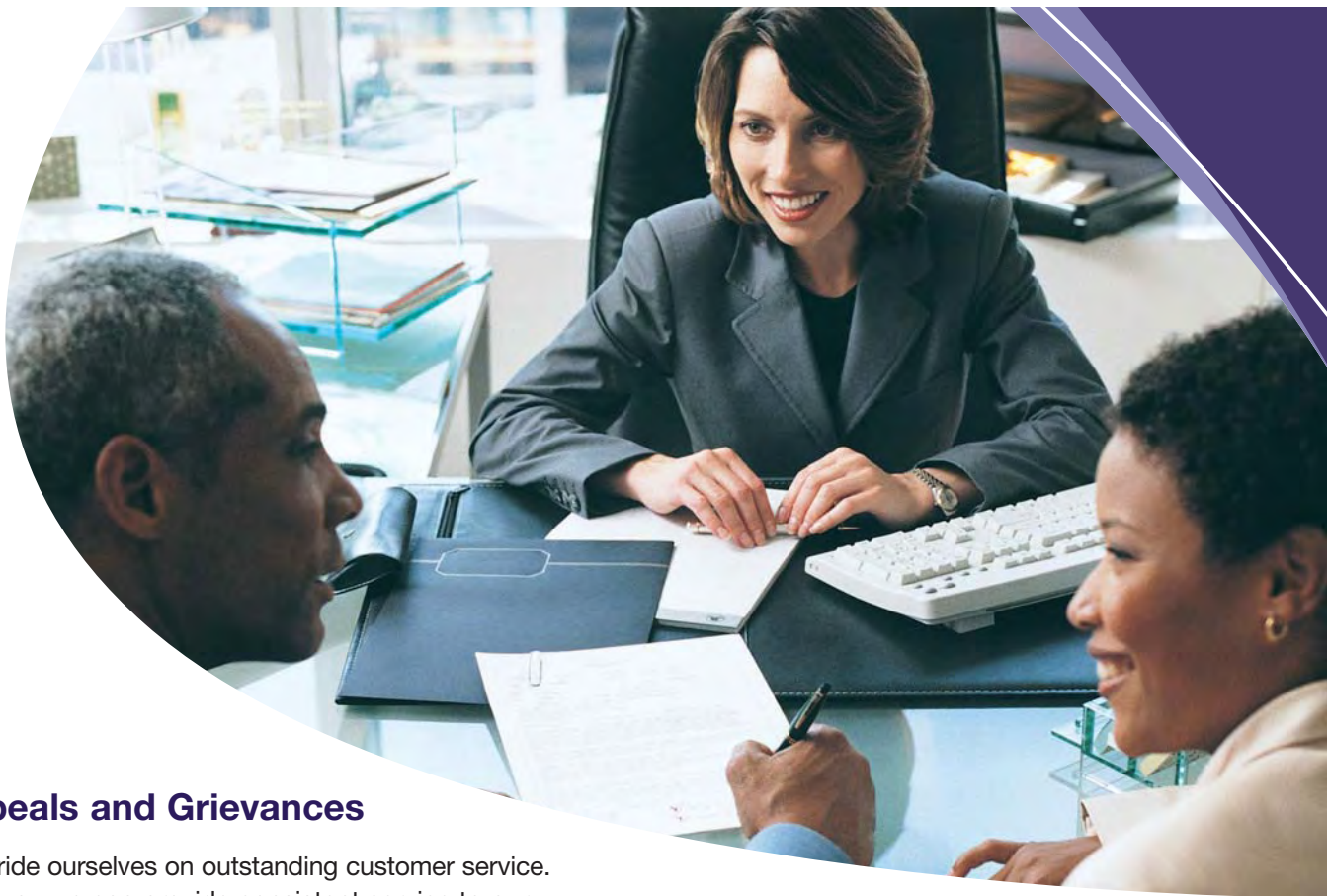
- A. Privacy of Health Information, which defines requirements designed to protect the privacy of individual healthcare information. It governs how healthcare providers, health plans, and clearing houses may use or disclose individual healthcare information, and guarantees specific rights to individuals regarding their own healthcare information.
- B. Security of Health Information, which defines standards for safeguarding and protecting the confidentiality and integrity of electronically transmitted or maintained healthcare information.
- C. Electronic Transactions Standards and Identifiers, which create national uniform code sets and identifiers across the healthcare industry.

HIPAA Privacy and Security

PHP has always recognized the importance of privacy and security of member health information. We have developed a strong corporate HIPAA compliance strategy and have taken all of the actions necessary to assure each of our business processes are reviewed, and modified if necessary, in accordance with HIPAA regulations.



To view or print your HIPAA Privacy Notice, go to www.phpni.com and log-on to the Members Portal and click on *HIPAA Privacy* under the *My Contracts* button. Follow the instructions provided.



Appeals and Grievances

We pride ourselves on outstanding customer service. One way we can provide consistent service to our members is by making healthcare coverage decisions that are based on their benefit contract. You have the right to appeal coverage decisions made by PHP. Although we hope you never need to file a grievance or an appeal, we appoint a member services coordinator to assist you throughout the process. Your Certificate of Coverage provides a full outline of the appeal and grievance procedure. The following is a summary of the process:

- 1. If you receive a denial of a claim or request for service, you may file a grievance, either orally or in writing.** All requests for grievances should be directed to the contact information listed at the front of this handbook to the attention of the member services coordinator.
- 2. You will receive an acknowledgement letter from PHP that will outline the process and timeframes for completion.**
- 3. Your member services coordinator will represent your grievance to the Grievance Committee.** The decision of the Grievance Committee will be communicated to you in writing.
- 4. If you disagree with the decision made by the Grievance Committee, you may submit a request for reconsideration (appeal).** The member services coordinator will arrange an appeal hearing and inform you of the date and time. You or your personal representative has the right to attend the appeal hearing. A summary of the discussion and decision of the committee will be communicated to you in writing.
- 5. If you disagree with the decision made by the appeal panel and your denial was based upon a medical judgement decision such as investigational or experimental; then you have the right to an external review by an independent review organization certified by the State of Indiana.** You must request an external review in writing. When PHP receives the request, the external independent review organization will review your case. The external review organization's determination is binding to PHP.

Understanding Your Pharmacy Benefits

To assist with receiving the highest quality of care at the most affordable price, your pharmacy benefit program has been designed to include prescription and specialty drug coverage as described in the table below.

Why is it important to understand my pharmacy benefit?

Getting the most out of your healthcare insurance coverage is important. If you understand your pharmacy benefit and how it works, you can use it to save money on the cost of your prescriptions and thus maximize your benefit.

It is important to talk to and work with your doctor on how best to maintain your good health and how to successfully manage any existing health conditions you may have. When medicines are needed to treat a health condition, be sure that you understand how to get the most effective drug treatment while controlling the cost of your prescriptions.



What is...

Generic

Covered drugs that are no longer protected by a drug company patent allowing other drug companies to manufacture equivalent versions of the same drug at a reduced cost.

Brand Formulary

A list of brand-name drugs that PHP participating network doctors are encouraged to prescribe when appropriate for treatment of a medical condition.

Brand Non-Formulary

Covered drugs that are not included in the formulary listing. You have the option to obtain non-formulary brand-name drugs with a higher pharmacy copayment.

Following is a summary, by plan type, of prescription and specialty drug coverage.

Covered Benefits	Copay Plans	Deductible Plans	HSA-Compatible Plans	
Individual Outpatient Prescription Drug Deductible	\$500 (Applies to all drug categories listed below except for Generics.)	Not applicable	Not applicable	
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% with a minimum of \$50 up to a maximum of \$100	Generic Drug: 30%* Formulary Brand: 50%* Non-formulary Brand: 50%*	HSA 1 & 2 30%*	HSA 3 & 4 0%*
Specialty Drugs <i>Up to 30 day supply.</i>	50% with a minimum of \$200 up to a maximum of \$400	50%*	30%*	0%*

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

Frequently Asked Pharmacy Questions

What is a formulary?

A formulary is a list of prescription drugs that PHP encourages our doctors to prescribe when appropriate. This formulary was developed with the help of area doctors and pharmacists. The formulary is updated quarterly and may change at any time.

Why does my health plan have a formulary?

Health plans use formularies to manage the cost of pharmaceutical healthcare. Formulary guidelines and protocols are used to encourage doctors to prescribe according to a predetermined therapeutic strategy developed by local health professionals.

What if my doctor wants to prescribe a non-formulary medication?

Your doctor may prescribe a prescription drug that is not on the PHP formulary. You have the option to receive the non-formulary medication at a higher pharmacy co-payment or to ask your doctor for a formulary medication.

Where can I get drug formulary information?

Our Customer Service Department can provide drug formulary information, or you may check for drugs listed by name on our Web site at www.phpni.com. All PHP participating doctors and pharmacies automatically receive a copy of the drug formulary each year along with updates throughout the year.

What are specialty drugs?

Specialty drugs are generally injectable, high-cost medications that have special handling requirements or require special training before use. These types of medications may be obtained through our specialty pharmacy, unless administered by a participating PHP network provider.

What is a generic drug? Is it safe to take instead of the brand-name drug?

A generic drug is a copy of the original drug that is no longer protected by a US patent. It is typically a drug that has been available for more than 20 years. Generic drug manufacturers are allowed to produce these medications after the patent for the



original brand has expired. Generic drugs are less expensive than brand-name drugs since generic manufacturers have not had to invest in the research and development of the drug when it was brought to market. Substituting a generic drug for a brand-name drug usually has no adverse effect. Check with your doctor before switching between brand-name and generic drugs.

What is a Prior Authorization?

Certain medications have a status of Prior Authorization Required (PAR). If your doctor wants to prescribe a PAR drug, he or she will submit a request for approval before the drug can be dispensed as a covered benefit. If your pharmacist receives notification that a drug you were prescribed requires prior authorization, ask your pharmacist to contact PHP.

What is Step Therapy?

Some medications require the use of an appropriate alternative therapy within a specified number of days before they can be covered by the plan. This process is referred to as Step Therapy.

Why am I requested to split tablets?

Many prescription drugs actually cost the same amount, regardless of the strength, meaning that a 20mg pill of a certain medication could cost the exact same amount as a 40mg pill. Specific medications are appropriate for tablet splitting and can offer immediate out-of-pocket savings to you. Talk to your doctor prior to tablet splitting.

Are there limits on the amount that can be dispensed?

Some medications may be subject to quantity level limits based on the manufacturer's packaging or insert. These Quantity Limits are designated in the Drug Formulary by (QL) next to the medication name. The purpose of these maximum quantity limits is to ensure the proper billing of products and/or encourage the use of appropriate medication regimens.

What if I am traveling and need medication?

If you are traveling and a medical emergency occurs that requires prescription medication, simply take your prescription to one of our 60,000 participating pharmacies across the nation, including Walgreens, CVS, and Wal-mart Pharmacy locations.

If you are unable to locate a participating pharmacy, take your prescription to a local pharmacy. You may be required to pay the full price of the prescription. When you return home, submit the pharmacy claim for reimbursement. In order for PHP to consider your claim, you must include the receipt, name of the medication, quantity, diagnosis, date of service, and your member name and number.

Are pharmacy services available on the Web?

At our site, www.phpni.com, you can refill prescriptions and check for possible drug interactions.

How can I lower my copayment and save money on my drug prescriptions?

By asking your doctor if a generic drug is available for the treatment of your medical condition, you may become eligible to take advantage of savings by lowering your pharmacy copayment. To allow for generic drug substitution, ask your doctor to use the signature line located on the right side of your prescription.

Where can I find additional information on prescription drug benefits?

For more information, and for a complete listing of the pharmacy providers in our service area, call our Customer Service Department or visit the Pharmacy and Provider Directory sections of our Web site at www.phpni.com.



PHP Health Management

To assist our members in practicing a proactive healthy lifestyle, we have created guidelines that are intended to help you achieve a healthy lifestyle and prevent disease. These guidelines are not intended to replace a healthcare professional's judgment; therefore, keep in mind that an individual with a high-risk family history or high-risk lifestyle needs to adjust his or her health schedule accordingly.

Blood Pressure

Maintaining a healthy blood pressure will help protect you from heart disease, stroke, and kidney problems.

Cancer

It is important to be screened for the following cancers: colorectal, breast and cervical (women), and prostate (men).

Cholesterol

Elevated cholesterol can cause heart disease and other health problems.

Routine preventive wellness exams and screenings

Routine preventive wellness exams and screenings by your healthcare provider are designed to protect your health through early detection and treatment of potential health issues. Frequency of visits and screenings may vary depending on medical history and other factors. Talk with your personal healthcare provider to determine what applies to you and your family. For a current listing of covered preventive benefits, please refer to the PHP website.

Immunizations

Immunizations are important for all ages, not just children. Most vaccines are given to babies and young children, but some are needed throughout your lifetime to make sure you stay protected. Although vaccine-preventable disease levels are at or near record lows, we cannot take high immunization coverage levels for granted.

For more information see: www.cdc.gov/vaccines

PHP covers the following preventive services:

Pediatric

- Newborn visits and well-child
- Newborn screening panels
- Newborn and young child developmental assessments
- Adolescent physicals
- Immunizations

Adult

- Adult physicals
- Sexually transmitted disease screening
- Mammograms and cervical cancer screenings
- Immunizations
- Preventive screenings such as:
 - Cholesterol
 - Mammograms
 - Cervical Cancer
 - Colon Cancer

Sources:

- 1 www.USPreventiveServicesTaskForce.org
- 2 www.brightfutures.aap.org
- 3 www.cdc.gov/vaccines



Recommended Pediatric Immunization Schedule

Age	HepB Hepatitis B	DTap/Td ap Diphtheria, tetanus, pertussis	Hib <i>Haemophilus influenzae type b</i>	Polio	PCV Pneumococcal Conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Varicella Chickenpox	HepA Hepatitis A	HPV Human Papilloma Virus	MCV4 Meningococcal conjugate	Influenza
Birth	√											
2 months	√ (1-2 mos)	√	√	√	√	√						
4 months	√	√	√	√	√	√						
6 months		√	√		√	√						
12 months	√		√	√	√		√	√				
15 months	(6-18 mos)	√ (15-18 mos)	(12-15 mos)	(6-18 mos)	(12-15 mos)		(12-15 mos)	(12-15 mos)	√√ (2 doses given 6 mos apart at age 12-23 mos)			
18 months							Catch-up	Catch-up				
19-23 months		Catch-up	Catch-up to 5 years	Catch-up	Catch-up to 5 years							√ (given each fall or winter to children ages 6 mos-18 yrs)
4-6 years		√		√			√	√				
7-10 years	Catch-up	Catch-up							Catch-up			
11-12 years		√		Catch-up			Catch-up	Catch-up		√√√	√	
13-18 years		Catch-up (Tdap/Td)								Catch-up	Catch-up	

Catch up - If your child's vaccination are delayed or missed entirely, they should be given as soon as possible.

Data compiled from the Centers for Disease Control and Prevention.

Recommended Adult Immunization Schedule

Age	HepB Hepatitis B	DTap/Tdap Diphtheria, tetanus, pertussis	HPV Human Papilloma Virus	Varicella Chickenpox	MMR Measles, mumps, rubella	Influenza	Pneumococcal (polysaccharide)	HepA Hepatitis A	Meningococcal	Zoster
19-26 years			√√√ 3 doses (females)		√√ 1 or 2 doses	√ 1 dose annually				
27-49 years		√ Substitute 1 time dose of Tdap for Td booster; then boost with Td every 10 years					√√ 1 or 2 doses			
50-59 years	√√√ 3 doses			√√ 2 doses				√√ 2 doses	√ 1 or more doses	
60-64 years					√ 1 dose	√ 1 dose annually				
+65 years		√ Booster every 10 years					√ 1 dose			√ 1 dose

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack of documentation of vaccination or have no evidence of prior infection).

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications.)

No recommendation

Diabetes Management *Sweet PHP Rewards*

Members with diabetes, or who have been referred by a physician, will be offered the Sweet PHP Rewards program. The program is intended to provide additional assistance to members in managing their condition and improving their overall health and well being. A nurse from our Diabetes Management Team will contact and encourage program participants to make good nutritional choices, eliminate tobacco use, and get adequate exercise. All qualifying members are encouraged to participate in this lifestyle changing program that gives them the opportunity to earn money saving rewards such as lower or eliminated copays.

Smoking Cessation Program

In effort to support healthy lifestyles, we have established a program to help members who want to quit their smoking habit.

Drug Benefit Program

Your health plan includes coverage for a unique prescription medication specifically developed to help kick the tobacco habit. Normal therapy is a 12 week course of medication consisting of three individual prescriptions. This benefit includes a free, online support program. For complete details, contact Customer Service.

Additional resources are available with MyNurse 24/7, MyHealth 24/7, AHA Start! program, and other Health Education information under the Wellness & Disease Management button on the Members portal at www.phpni.com



Healthy Moms and Babies

PHP provides pregnant women with a case manager anytime there is a risk for pregnancy complications. Education from the experts in obstetrical and neonatal care will guide you through the process of receiving enhanced coordination for the care of you and your baby. Please note that all our case managers are qualified registered nurses under the guidance of a physician.

Perinatal Case Management

The perinatal program focuses on the mother at high risk for developing any pregnancy complications. Based on ongoing assessments, the perinatal case manager works directly with you and your healthcare providers to coordinate the most appropriate plan of care. This program's key to success is education and support for you and your family. Nurses are on hand to provide important information about the following:

- **Signs and symptoms of preterm labor**
- **Signs and symptoms of hypertension**
- **Fetal movement assessment**
- **Other factors which may place you at risk**

Neonatal Case Management

Despite the best efforts of healthcare providers, you may deliver early, or other complications may arise. Our neonatal case managers work with you and your healthcare providers to help coordinate care during the hospital stay of your baby. Our case managers work closely with other members of the healthcare team to facilitate a timely and safe discharge from the hospital and to assist in coordinating ongoing necessary healthcare services.

Education is also a key to the success of this program. For example, you can learn how to be an effective member of your child's healthcare team; how to identify and access information and other resources to facilitate quality care; and how to communicate effectively with PHP representatives and your healthcare providers. When you are equipped with knowledge and understanding, you can be a better advocate for your baby.

If you have questions regarding this program, or would like additional information on other case management services available, please contact our Medical Management Department at (260) 432-6690, Extension 12, or 1-800-982-6257, Extension 12.



MyHealth 24/7

MyHealth 24/7 is an interactive, online, health resource benefit for our members. This valuable tool acts as your 24-hour medical advisor, and can help you find solutions to your most common health problems. When you have a medical question or concern, anytime of the day or night, just click onto the PHP Web site at www.phpni.com.

Once you have logged on and selected MyHealth 24/7, use the **Health & Symptom Evaluation** tab to evaluate your symptoms, overall health, and specific chronic conditions. This tab also contains information that can help you understand what conditions you may have and how to treat them.

You may perform a personal **Health Risk Assessment**, which educates you about preventable illness. The information from your assessment can be saved for future reference. If appropriate, you can then engage in self-care programs prior to seeing the doctor or use these programs as part of a treatment plan and track your progress online.

Medical content is created by board-certified physicians in 20 specialties, and covers over 95% of the symptoms that make people seek medical care.

The MyHealth 24/7 featured tabs are described below:

- **Medical Library** – Stores information, articles, videos, and photos on healthcare topics.



- **Health Helpers** – Gives access to tools and calculators to help you improve and maintain your weight.

Healthy Assessments – Helps you define and practice habits that are appropriate for your lifestyle.

Health Trackers – Keeps track of all your health numbers, such as cholesterol and blood pressure.

- **Pharmacy** – Explains facts about medications, compares drugs, and helps you lower your medication expenses.
- **My Health Files** – Stores and integrates personal health data, historic record of health risk assessment results, and email preferences for all MyHealth24/7 Health Tips and updates.
- **News, Forums and Communications** – Gives you access to articles and newsletters, and forums for discussions with other members.

To activate your MyHealth 24/7 account, log-on to www.phpni.com and click on Wellness & Disease Management located in the Members portal. Next, click on MyHealth 24/7 in the menu and follow the instructions under the first-time user section.



MyNurse 24/7

Questions about medicine that you are taking or symptoms you might be experiencing can come up at all hours of the day and night. It is nice to have a quick response to your healthcare questions. That is why we offer MyNurse 24/7, which is a toll-free help line for noncritical situations. This free benefit allows members to speak with experienced, knowledgeable nurses about specific health concerns. Nurses will answer your questions with sound, clinically based information. Since they are available 24 hours a day, 7 days a week, and 365 days a year, you can have peace of mind when it comes to getting the answers you need.

Call anytime at 1-800-931-4714.

In the case of an emergency, please call 911.



Vision Discounts for prescription eyeglasses and accessories

Vision discounts are included free of charge with your health insurance coverage. You can save up to 40% on prescription eyeglass frames and lenses at thousands of vision providers nationwide depending on the hardware you choose. There is no paperwork or insurance claim involved. You receive a discount directly off the retail cost of your eyeglasses at the time of purchase.

How does the program work?

We offer two options and the choice is yours!

EyeMed Vision

Shortly after your health insurance coverage takes effect, a personalized EyeMed ID card (one per family) is mailed to your home. Simply visit the participating EyeMed provider of your choice and present your EyeMed vision card to receive a discount. To locate the providers nearest you, log-on to www.eyemedvision-care.com and select "Access" as your provider network.

Insight of Wellness

PHP participating providers throughout Allen and several surrounding counties have teamed up to offer you value-added savings. As a member, you and your covered dependents can receive a discount off the retail cost of eyewear, contact lenses, and laser vision correction procedures when these items are purchased at a participating PHP network eyecare location. Just show your PHP card prior to making your purchase and save money.

What about Eye Exam Benefits?

Many of our healthcare benefit plans include one routine vision exam per calendar year for refractive correction when performed by a participating provider. The benefit has no limit on the number of covered exams for dependents under the age of 18. To be sure of your coverage, please contact our Customer Service Department prior to services being rendered.

Discounts at Health Clubs and Community Classes

PHP gives our members tools and information to help them meet their personal health and fitness goals. Our Healthy Starters Program is a benefit we make available to our members. Just by showing your PHP member ID card, you are eligible to receive a variety of special discounts at selected area health clubs and community classes, such as:

- **Discounts for first aid and CPR courses**
- **Free trial memberships or discounts on annual memberships**
- **Discounts on activity fees, enrollment fees, and training packages**
- **Discounts on medically supervised programs**

To learn more about these programs and for a list of participating health clubs and resource centers, click on *Individuals & Families* at www.phpni.com and select *Health Club and Class Discounts* under *Member Discounts*.



Sporting Event Discounts

PHP has teamed up with several area sports teams to offer discounts to our members and their families. These teams currently include the Fort Wayne Komets, Fort Wayne Mad Ants, Fort Wayne TinCaps, and South Bend Silver Hawks. **Our Purple Card Night Program entitles you to receive discounts on ticket prices** when you show your PHP membership card at the ticket window.

Please note that you only receive a discount on the designated Purple Card Night. The discounts vary by team. For more information and schedules on these events, please visit the For Members section of our Web site at www.phpni.com and click on Member Resources.

PHP HealthNews Newsletter

Being and staying healthy is important. To help you do just that, we publish a quarterly newsletter loaded with everyday health and wellness information such as nutrition, exercise, child safety, seasonal health concerns, medical news and more. Each issue also includes an update of our participating providers, as well as regional announcements, discounts, and health-related events.

HealthNews is a free health resource to help you take an active role in managing your health by keeping you informed with reliable, practical, and up-to-date information presented in a fresh, easy-to-understand format. All material included in each and every publication is overseen by seasoned editors and backed by medical review.

Each HealthNews issue is mailed to your home quarterly and can also be accessed online through the *About PHP* section of our Web site at www.phpni.com.



The PHP Web site

We understand how important it is for you to have access to information about your health plan benefits. With that in mind, we have developed a secure, interactive Web site which provides you a wealth of information and health management tools that are available at your convenience, day or night. Below is a list of some of the features and information you will find in the Members portal:

- View member profile
- Change address
- Change email/password
- Review your Benefit Plan & Contracts
- View Certificate of Coverage and HIPAA Privacy Notice
- View claims
- Order ID card
- Order Explanation of Benefits
- MyHealth 24/7
- Get forms
- Get updated Provider Directory
- Obtain updated PHP Formulary
- Frequently asked questions
- Contact PHP



Tips:

- Choose a Password that is easy for you to remember. For privacy reasons, each family member is required to have an individualized User ID and Password.
- Write your User ID and Password down. File it with your health insurance information for safekeeping.



- Note that once you have registered for the first time and created your account, PHP will be able to access your ID. However, we will NOT be able to access your Password. If lost, passwords can be reset.
- Call PHP Customer Service Department if you need assistance.

Visit the PHP
Web site at
www.phpni.com

The following terms and definitions are intended to be used only as a general reference guide to help individuals better understand the terminology used in the managed healthcare industry. They are not to be construed as legal definitions for your benefit coverage. For benefit coverage purposes, the terms of the applicable contract will determine coverage. Participating members may also refer to their Certificate of Coverage or Contract.

Admitting Physician The doctor who is responsible for admitting a patient to a hospital or other inpatient healthcare facility; and in many cases, the one who is coordinating a patient's medical care during his or her stay.

Adverse Benefit Determination A denial, reduction or termination or a failure to provide or make payment for a benefit in response to a Member's request for benefits. An adverse benefit determination also includes an initial eligibility determination and rescission of coverage.

Allowed Amount Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Alternate Facility A nonhospital healthcare facility that provides one or more of the following on an outpatient basis: surgical services, emergency health services, rehabilitative services, laboratory or diagnostic services; or provides on an inpatient or outpatient basis: mental health or chemical dependency services. The facility may include an attachment to a hospital, but does not include a doctor's office.

Amendment A description of additional provisions attached to a contract. An amendment is valid only when signed by an officer of a healthcare insurance company.

Appeal A request for your health insurer or plan to review a decision or a grievance again.

Authorized or Authorization Process by which the Medical Management Department approves high-dollar, complicated, or unusual medical services.

Balance Billing When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you.

Benefit Plan Services an insurer, government agency, or health plan offers to a group or individual under the terms of contract.

Benefits The coverage of healthcare services and related items provided under the terms of a contract.

Calendar Year January 1 through December 31 of any given year.

Case Management A process used to manage the care of a covered person when specific healthcare needs are identified. The goal is to provide the highest quality care in an efficient and effective manner to benefit the patient receiving treatment.

Certificate of Coverage A statement of the coverage and provisions of a master contract in group insurance that is issued to individuals covered in the group.

Claim Information submitted by a provider or covered person to establish that medical services were provided, from which processing for payment to the provider or covered person is made. The term generally refers to the liability for healthcare services received by covered persons.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) A federal law that requires employers to offer continued health insurance coverage to specific employees and their dependents who have had their group health insurance coverage terminated. This act applies to employers with 20 or more eligible employees.

Co-insurance Your share of the costs of a covered health care service, calculated as a percent (for example, 40%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Complaint An oral or written statement of dissatisfaction with a health plan or with health services provided through the health plan.

Complications of Pregnancy Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean section aren't complications of pregnancy

Confinement/Confined Referring to inpatient care, it is an uninterrupted stay following formal admission to any hospital, skilled nursing facility, or alternate facility.

Contract (1) An agreement entered into by two or more persons under which one or more of them agree, for a consideration, to do or refrain from doing acts in accordance with the wishes of the other party(ies). (2) In insurance, the agreement, by which an insurer agrees, for a consideration, to provide benefits, reimburse losses, or provide services for an insured. A policy is the written statement of the terms of the contract. (3) An agreement under which an agency or agent does business with an insurer.

Coordination of Benefits (COB) The coordination of claims handling by primary and secondary insurance carriers to ensure that any person with duplicate coverage does not receive more than 100% reimbursement for any healthcare costs.

Co-payment A fixed amount (for example \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cosmetic Procedure Any procedure that improves physical appearance without correcting a physical function.

Coverage or Covered The fact that the health-care services provided to an insured person will be paid by the insurance company according to the terms, conditions, limitations, and exclusions of the contract. Payment will occur provided that the services are rendered when that contract is in effect.

Deductible The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Dental Care All services provided by or under the direction of a dentist. Such services include: the care of teeth and the surrounding tissues; correction of an overbite or underbite; any surgical procedure that involves the hard or soft tissues of the mouth.

Dentist Any doctor of dental surgery (DDS) who is licensed and qualified to provide dental care under the law of jurisdiction in which treatment is received.

Dependent A person who relies on a spouse, parent, grandparent, legal guardian, or one with whom he or she resides, for healthcare insurance. The definition of dependent is subject to differing conditions and limitations between healthcare plans.

Diagnosis The identification of a disease or condition through analysis and examination.

Disclosure Authorization Form A form authorizing the disclosure of personal information obtained in connection with an insurance transaction. Insurers are required to give applicants advance notice of their information practices. Among other things, the form must state the kind of information collected and to whom information may be disclosed. A copy of this form can be found in the Member section of the PHP Web site at www.phpni.com.

Durable Medical Equipment (DME) Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Doctor Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed and qualified under the law of jurisdiction in which treatment is received.

DOS (Date of Service) The date when a covered person is provided with a healthcare service.

Drug Formulary A list of prescription drugs that are approved for use and covered by an insurance plan. These prescriptions may be dispensed to covered persons at participating pharmacies. The formulary is subject to review and change.

Effective Date The date a contract becomes in force.

Eligibility Date The defined date a covered person becomes eligible for benefits under an existing contract.

Eligible Expenses Reasonable and customary charges for healthcare services incurred while coverage is in effect.

Emergency Medical Condition An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care Emergency room services received in an emergency room.

Emergency Services Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA) This law mandates reporting and disclosure requirements for group life and health plans.

EOB (Explanation of Benefits) A statement of coverage sent to covered persons which lists any health services that have been provided as well as the amount billed and payment made by the health plan for those services.

Excluded Services Health care services that your health insurance or plan doesn't pay for or cover.

Experimental, Investigational or Unproven Any healthcare services, products, or procedures considered by a health plan or government agency to be ineffective, unreasonable, unnecessary, or not proven effective through scientific research.

FSA (Flexible Spending Account) A way for covered persons to use pre-tax dollars, money set aside from their salary that may be reimbursed, to pay for any healthcare services not covered under the terms and conditions of their contract.

Generic Drug A chemically equivalent copy designed for a brand-name drug that has an expired patent. A generic drug is typically less expensive and sold under a common or "generic" name for that drug, not the brand name (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name Diazepam). Also called generic equivalents.

Grievance A complaint that you communicate to your health insurer or plan.

Group Contract An agreement made between a health plan and a subscribing employer group which specifies all terms and conditions of the plan. This contract is generally limited to one year and may be available for renewal thereafter.

HDHP (High Deductible Health Plan) A health insurance plan designed to save on insurance premium costs by raising deductible levels. Qualifying minimum and maximum deductible levels, annual out-of-pocket maximums (including deductibles and coinsurance) for HDHPs are defined by federal law and may change from year to year.

Habilitation Services Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Healthcare Services Any services or supplies covered under contracts that are used in the maintenance of health or treatment of disease.

HIPAA (Health Insurance Portability and Accountability Act of 1996) The federal law that established portability and administrative simplification requirements for health plans and issuers of health coverage.

Home Health Care Health care services a person receives at home.

Hospice A facility or program engaged in providing palliative and supportive care of the terminally ill.

Hospice Services Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospital A twenty-four hour facility that is operated in accordance with the law and which is primarily focused on the treatment and care of injuries and sickness, usually on an inpatient basis.

Hospitalization Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care Care in a hospital that usually doesn't require an overnight stay.

HSA (Health Savings Account) An account allowing employees to pay for current healthcare expenses and save for future qualified medical and retiree healthcare expenses on a tax-free basis. An individual must be covered by a high deductible health plan to be eligible for an HSA.

ID (Identification Card) A card issued by a carrier, health plan or Third Party Administrator identifying the person as being eligible to receive coverage for services.

Individual Policy A type of health insurance coverage that is made available to individuals and families, rather than to employer groups or organizations.

In-network Healthcare services received within the authorized service area by a participating provider of the health plan.

In-network Co-insurance The person (for example 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Inpatient A person who is registered as a bed patient in a hospital and receives physician services for at least twenty-four consecutive hours.

Insurance A formal social device for reducing risk by transferring the risks of several individual entities to an insurer. The insurer agrees, for a consideration, to assume, to a specified extent, the losses suffered by the insured.

Insurance Department A governmental bureau in each state (and the federal government in Canada) charged with the administration of insurance laws, including the licensing of agents and insurers and their regulation and examination. In some jurisdictions the department is a division of another state department or bureau.

Limits The maximum amount of benefits payable for a given situation or occurrence, e.g., one eye exam per year.

Mail Order Drug Provider A prescription medication vendor who has a contract or service agreement with a health plan in order to provide medications to the plans members via mail order.

Medically Necessary Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medicare A program under the United States Social Security Act that provides healthcare to those over the age of 65 as well as the disabled.

Member or Covered Person In reference to either a subscriber or an enrolled dependent, a member is one who both meets the eligibility requirements of the contract and is enrolled for coverage under the contract.

Mental Health Services Services for the diagnosis and treatment of mental illness, including alcoholism and chemical dependency.

Misrepresentation Omitted, incomplete, or false information during the application process which, if known by the insurer, may have caused the insurer to not issue the policy or to add restrictive terms and/or additional premium.

Network The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred or Non-Participating Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Open Enrollment Period After the initial open enrollment period, the time where eligible persons may change health or benefit plans usually without evidence of insurability or waiting periods. This period of time usually occurs annually.

Ophthalmologist A trained and licensed medical doctor who specializes in treating conditions and diseases of the eye.

OOA (Out-of-Area) A reference to services that are outside a certain geographic area generally referred to as the service area or out of the network.

OTC (Over the Counter) Medications that are available without prescriptions.

Out-of-Network Co-insurance The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Network Services When covered persons receive services from a non-contracted provider.

Out-of-Pocket Costs/Expenses Payments for healthcare services made directly by a covered person. Examples include co-insurance and deductibles.

Out-of-Pocket Limit or Maximum The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance doesn't cover. Some health insurance plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Outpatient A person who receives healthcare services without being admitted to a hospital.

Par or Participating Refers to the status of a provider of products or services being in a service agreement with a health plan or insurer.

Participating Provider A provider of healthcare, such as a doctor or hospital, who has entered into a contract or service agreement with an insurer in order to provide healthcare to the plan's members.

Patient Protection and Affordable Care Act (PPACA) Also known Health Care Reform or the Accountable Care Act is a federal statute that was signed into law in the United States on March 23, 2010.

Physician Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received, or as defined in the summary plan description.

Physician Services Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Place of Service The location where health services are rendered (e.g., office, home, hospital, etc.).

Plan A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Policy Year The period between policy anniversary dates.

Preauthorization/Prior Authorization A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Pre-Existing Condition Any health problem or illness that exists prior to the coverage of health insurance. This condition can cause higher premiums, the exemption of the condition under

Preferred Provider A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription An order for medication or treatment given by a participating prescriber.

Prescription Drug Coverage Health insurance or plan that helps pay for prescription drugs and medication.

Prescription Drugs Drugs and medications that by law require a prescription.

Prescription Order or Refill The dispensing of a prescription medication by a participating pharmacy as ordered by the prescriber.

Preventive Wellness services that generally do not require a copay or coinsurance.

Primary Care Provider A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Primary Plan/Secondary Plan The primary plan includes benefits which are considered before any other healthcare plan for services rendered. The secondary healthcare plan assumes responsibility of payment for charges not covered by the primary plan as defined under their contract.

Prior Carrier Deductible Credit A benefit under some, but not all, plans which allows covered persons and/or their dependents credit for deductibles already accumulated for the calendar year under their employers previous health insurance program. The amount of deductible met under the covered persons prior insurance for the same calendar year may apply toward his or her new deductible requirement.

Provider A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited by required by state law.

Qualified Medical Child Support Order (QMCSO) A medical child support order that requires parents to provide health coverage for their children.

Reconstructive Surgery Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referred or Referral A participating providers written request to have a covered person receive benefit coverage for services rendered by a nonparticipating provider as well as the insurers written approval for such request.

Rehabilitation Services Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reinstatement Issuance of a policy which has lapsed due to non-payment. The new policy may have a new effective date and new benefit waiting periods.

Renewal Continuance of coverage under a policy beyond its original term by the acceptance of a premium for a new policy term.

Rescission An action taken by the insurer which renders the policy unenforceable as of the policy's effective date--no benefits are payable. Rescission may occur if there was a misrepresentation during the application process.

Self-Funding or Self-Insurance A healthcare program in which employers fund benefit plans from their own resources without purchasing insurance. Self-funded plans may be self-administered, or the employer may contract with an outside administrator for an administrative services only (ASO) arrangement. Employers who self-fund can limit their liability via stop-loss insurance on an aggregate and/or individual basis.

Service Area The geographic area within certain boundaries that is approved for providing service to a health plan's members.

Sickness Any physical illness, disorder or disease including pregnancy but not mental illness.

Skilled Nursing Care Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician is a provider who has more training in a specific area of health care.

Subrogation Clause A clause giving an insurer the right to pursue any course of action, in its own name or the name of a policy owner, against a third party who is liable for a loss which has been paid by the insurer. One of its purposes is to make sure that an insured does not make any profit from his insurance. This clause prevents him from collecting from both his insurer and a third party. It is never part of a life insurance policy.


Subscriber An individual who is enrolled for coverage under a contract and who is responsible for payment of premiums or whose employment is the basis for membership.

Surgi-Center A healthcare facility that is physically separated from a hospital that provides pre-scheduled outpatient surgical services. This is also known as a freestanding outpatient surgical center.

Termination Date The date that a group or individual contract expires, or the date that a subscriber and/or member ceases to be eligible.

Third Party Payor A public or private organization that pays for or underwrites coverage for healthcare expenses or another entity, usually an employer.

UCR (Usual, Customary and Reasonable) The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.



Urgent Care Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Urgi-Center A licensed medical center that provides urgent care.

Waiver A surrender of the right to benefits for a specified condition known to exist prior to or at the time of application, and any future complications that may arise. Waivers automatically terminate from the policy at the end of their specified duration.

Workers' Compensation A system that compensates employees for any work-related injuries in order to avoid lawsuits against their employers.

How to Contact Us

We are readily available to support you when you need healthcare assistance. Getting your questions answered is easy—you can reach us by phone, by our Web site, or by visiting us in person. Questions about benefits, eligibility, claims payment, prior authorization, or the participation status of doctors, hospitals, or other facilities can be addressed in person by our Customer Service Department Monday through Friday, 8:00 am to 5:00 pm.

You can also browse our Web site medical library for health-related information. If you do not find an answer to your coverage questions, do not hesitate to contact us. We are here to help you!

Phone Numbers

Voice: (260) 432-6690, ext. 11

Toll-free: 1-800-982-6257, ext. 11

Hearing Impaired: (260) 459-2600

Fax: (260) 432-0493

Address

Attention: Individual Product

PHP

8101 West Jefferson Blvd.

Fort Wayne, IN 46804-4163

Web site

www.phpni.com

Email

custsvc@phpni.com

To help us in our efforts to provide excellent service, be sure to include your name and birth year when using email.

Payment Remittance Address

PHP

PO Box 10930

Fort Wayne, IN 46854-0930

How to file a claim

If you receive services from a provider in the PHP network, they will submit claims on your behalf. However, if you receive services from a provider outside of the PHP network, you are responsible for submitting claims to PHP within 90 days of the service. **Your claim should include the following information:**

- **Your name and address**
- **Patient's name and birth year**
- **Name and address of the provider of services**
- **Diagnosis from the provider**

Submit claims to:

Attention: Individual Product

PHP

PO Box 2359

Fort Wayne, IN 46801-2359



The insurance your health deserves.

8101 West Jefferson Blvd.
Fort Wayne, IN 46804

www.phpni.com