PHP Member Handbook

Make the most of your health insurance benefits

PHP

How to contact PHP

A.M. Best is the only global credit rating organization with a unique focus on the insurance industry. Best's Ratings, which are issued through A.M. Best Rating Services, Inc., are a recognized indicator of insurer financial strength and creditworthiness.

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 website, 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, by appointment, with PHP Customer Service Monday through Friday, 8:00 am to 5:00 pm.

Your Certificate of Coverage, Summary of Benefits and Coverage (SBC), and HIPAA Privacy Notice are available online at phpni.com. Log-on as a Member and click the My PHP arrow to view complete account information. If you do not find the answers you are seeking, do not hesitate to contact us. We are here to help you!

Website:

Member Account: Set up your member account at www.phpni.com.

Online Chat: Chat real-time with a customer service rep through your member account.

Email:

custsvc@phpni.com
To help us provide excellent service, be sure to include your name and date of birth when using email.

Phone:

Voice: 260-432-6690
Toll-free: 1-800-982-6257
Fax: 260-432-0493

Attention to:

Customer Service
Physicians Health Plan *(PHP)*
1700 Magnavox Way, Suite 201
Fort Wayne, IN 46804

TABLE of CONTENTS

PHP MEMBER INFORMATION

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You can also browse our website to view your *Certificate of Coverage, Summary of Benefits and Coverage*, and *HIPAA Privacy Notice.* 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 Informed

Let us know when you have a life change, so we can keep your records up to date. Please contact your PHP Customer Service Department when you experience:

- An address or phone number change
- Change in employment
- Birth or adoption
- Additional insurance coverage
- Marriage or divorce
- Death in the family
- Dependent status change
- Student attending college away from home

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 Linea de Lenguajes de AT&T. Nuestro departamento de Servicios al Cliente coordinará con un traductor para conseguir respuestas inmediatas a sus preguntas. Llámenos o escríbanos para más información.

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INTRODUCTION

PHP is dedicated to the health and well-being of those we serve. 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 every day.

As healthcare costs soar and employers try to manage these costs, more employers are depending upon health education and wellness programs for their employees in order 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

We are a local, not-for-profit health benefits 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 our region. 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
- Many tools and resources available to help you navigate healthcare and wellness

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 community. We build long-term relationships with area healthcare providers in order to benefit you and partner with doctors who provide the best care to their patients. We put our members first!

MEMBERS RIGHTS AND RESPONSIBILITIES

Become Familiar With your Rights and Responsibilities as a PHP Member, such as:

Actively participating in decisions regarding your own health and treatment options

Expecting healthcare practitioners who participate with PHP to provide treatment with courtesy, respect, and with recognition of your dignity and right to privacy

Taking an active role in managing your healthcare

You Have the Right To:

- Receive a copy of PHP's *Member Rights and Responsibilities* statement and a copy of our *Notice of Privacy Practices*.
- Exercise these rights regardless of your race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or education background, economic or health status, English proficiency, or reading skills.
- Actively participate in decisions regarding your own health and treatment options.
- Receive information and prompt responses about PHP, services, benefits, and participating practitioners and facilities that provide care.
- Receive information about an illness, the course of treatment and prospects for recovery in terms that you can understand.
- Receive an explanation about non-covered services.
- Get medically necessary care from participating network specialists, hospitals and other healthcare providers.
- Receive emergency services when there is reasonable cause to believe that an emergency medical condition exists.
- Get information about copayments, coinsurance and fees that you may pay.
- Expect healthcare practitioners who participate with PHP to provide treatment with courtesy, respect, and with recognition of your dignity and right to privacy.
- Communicate complaints or appeals about PHP or the care provided through the established appeal and grievance procedure found in your *Member Handbook,* in your *Certificate of Coverage,* or on the PHP website at phpni.com.
- Refuse treatment or leave a medical facility if you are willing to accept the financial responsibility and consequences of that decision.
- Have access to your personal health records, request amendments to your records, request an accounting of disclosures, and have confidentiality of these records and member information protected and maintained in accordance with state and federal laws and PHP policies. You have the right to review and get a copy of certain personal health information (there may be a fee for copies).
- Make recommendations regarding PHP's *Member Rights and Responsibilities* statement.
- Call or write us anytime with helpful comments, questions and observations, whether concerning something you like about the plan or something you feel is a problem area, with the expectation of a timely response from PHP staff.

You Have the Responsibility To:

- Be courteous and respect the rights, needs and privacy of other members, patients, office staff and providers of care.
- Review and understand your benefit structure, both covered benefits and exclusions, as outlined in this *Member Handbook* and/or *Certificate of Coverage*.
- Supply information (to the best of your ability) that the organization and its practitioners and providers need in order to provide care for you and/or administer benefits.
- Take an active role in managing your healthcare to understand your health concerns, participate in treatment goals, and follow the plan and instruction for care that you have agreed to with your practitioners.
- Pay copayments or required coinsurance and provide current information regarding your PHP membership status to any PHP participating practitioner or provider.
- Follow established protocols for filing a complaint, appeal or grievance concerning medical or administrative decisions you feel are in error.
- Follow the coverage rules outlined in your *Certificate of Coverage.*
- Understand your identification card; only you and your covered family members may use your identification cards.
- Know what is considered emergency care and what is considered urgent care, recognizing that non-emergent care received in the emergency room will not be covered.
- Make sure you have the correct authorization prior to receiving certain services, including inpatient hospitalization and out-of-network treatments.
- Not be involved in dishonest activity directed to PHP or any healthcare provider.

FINDING A DOCTOR OR PROVIDER

How Do I Find a Participating Doctor or Healthcare Provider?

Finding a PHP participating healthcare provider is easy, just refer to our online provider directory or give us a call. The provider directory is available on our website at **phpni.com**. A printed version is available by request. The directory lists participating doctors by city, specialty, and other criteria, to help you locate a provider in your network. 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 PHP Customer Service. Show your ID card at each visit.

Know Your Network

Make sure you select your assigned network when searching for a provider. ***Your network can be found on your ID card.*** Verifying whether a provider is participating BEFORE you receive services is the best way to ensure claims are paid in-network, which can provide significant savings. Please be sure you are searching the correct network in the provider directory. You may always call Customer Service to verify the status of a provider or to confirm your network.

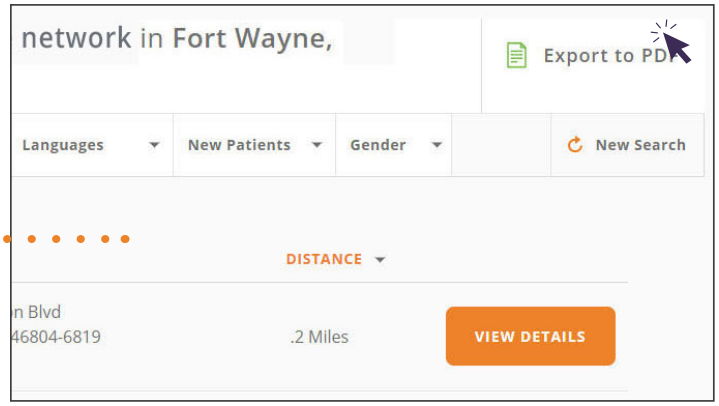
What if I need medical care that is not available from a doctor participating in the network?

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 page 10 of this handbook or call PHP Customer Service.***

PHP PROVIDER DIRECTORY ONLINE

Login as a member at **phpni.com** and select *Find Care* from the left-hand menu. You will be given the option to search by a variety of categories, for example: *Medical Practitioners and Specialists, Hospitals and Facilities, Lab and Testings*, and more.

You can also select **Export to PDF** to create a printable version of your search results.



USING OUR SERVICES

Network/ID Card Information

Please show any provider your ID card at the time of service. Your primary network(s) are displayed on the front of your ID card.

FRONT BACK

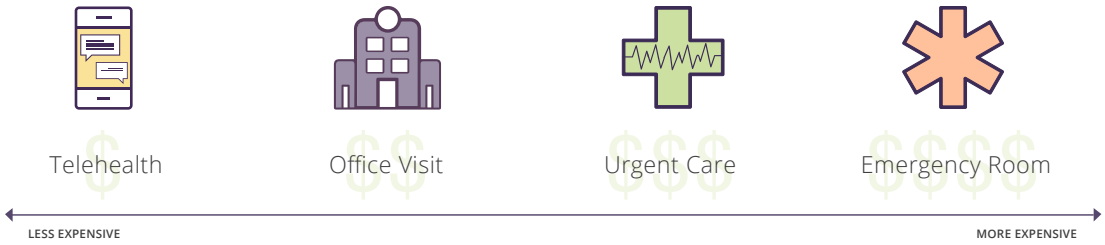
Need a temporary ID card?

Log into your member account at **phpni.com** and select **Member ID Card** from the menu.

You may view or print a copy of your ID card, and order a new member card, as well.

Make the most of your benefits—cost of care

When you need care, your family doctor or pediatrician should be your first call, but when you can't get an appointment, your choices can make a big difference in terms of cost and convenience. Weigh your options and choose a level of care appropriate for the situation.



Telehealth: PHP offers telehealth solutions for your use. Please visit **phpni.com** for more information.

Office Visits: Family physicians are your trusted advisor and should be the first path to treating chronic conditions.

Urgent Care: Facilities must meet specific guidelines to be designated as an urgent care clinic. Generally, a doctor is on-site and can treat a multitude of injuries or illnesses such as upper respiratory infections, minor burns, sprains, cuts, fevers, and rashes. Many urgent care centers are able to do simple lab tests and x-rays. Urgent care clinics should not be used to treat chronic conditions and you should never use an urgent care clinic as your routine physician.

Emergency Room (ER): Use the ER for life-threatening or serious situations that may require a specialist or advanced diagnostics. These situations may include heart attacks, strokes, serious injuries, extensive burns, or loss of consciousness. ER visits usually have higher copays and cost sharing compared to urgent care clinics described previously. Services may not be covered by insurance if they are not true emergency situations.

Seeking 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 PHP network area?

You should dial 911 or contact the nearest emergency service. Discuss with your doctor what to do in the event of an urgent medical situation before it happens. Be prepared and have information about existing healthcare conditions and any medications currently being taken. This information will assist the emergency healthcare providers and will improve your likelihood for a healthy outcome.

PHP RESOURCES ONLINE

We understand how important it is for you to have access to information about your health plan benefits. With that in mind, PHP has a secure, interactive website which provides information and health management tools available at your convenience, day or night. Below is a list of some of the features and information you will find in the ***Member portal:***

Set your electronic communication preferences

- View member profile
- Change address
- Change email/password
- Review your *Benefit Plan & Contracts*
- View *Certificate of Coverage* and *HIPAA Privacy Notice*

View and print Explanation of Benefits (EOB) and Annual Statement

- View claims
- Order ID card
- Print temporary ID card
- *MyNurse 24/7 and Parkview OnDemand*
- *Treatment Cost Estimator*
- Find forms and other resources

Search or create a provider directory

- Search PHP Formulary *(Prescriptions)*
- Frequently Asked Questions
- Contact PHP

Get Started on the PHP website

Below are basic instructions for getting started on the PHP website. *For privacy reasons, each family member over 17 years of age is required to have a unique account and email address.*

1. **Go to www.phpni.com.** *(You are at the PHP home page)*
2. Select *LOGIN* at the top right corner of your screen. Then select *MEMBER* from the User Login drop down menu.
3. Enter your *User Name* and *Password* to access your account.

First Time Users

First time users *must register* to gain access. If you have not previously registered, select *Member Registration* on the Login screen. Then complete the *Member Information* page.

Member Information Page

1. Enter your PHP Member ID. *(If you do not have your member ID, you may enter your Social Security Number and last name).*
2. Enter your date of birth.
3. Supply your email address-**this will become your username**; then create a password.
4. Enter security information and set your electronic communication preferences.
5. Complete the email verification process.

NOTE: Your PHP ID Number can be found on your Member ID Card.

PHP Go! Member mobile app

A mobile app designed for you! PHP's member mobile app, **PHP Go!** gives you access to important information and tools to make the most of your health plan, in the palm of your hand. The best part—it's **FREE.**

Here are some features of the PHP Go! app:

- **Member ID card**
  Instant access to view or download your Member ID card, on your mobile device.
- **View your claims**
  View your medical claims in the mobile app, check claim status, or download EOBs for health-related expenses.
- **My Benefits and Year-to-Date totals**
  View benefit information and monitor your year-to-date totals tracking deductibles and out-of-pocket expenses.
- **Find care**
  Find nearby physicians or facilities that are in their network.
- **Wellness**
  Access our telehealth services, nurseline, and more.
- **Contact**
  Reach out to our friendly, local customer service team, directly from the mobile app.

Download PHP Go! Today

To get started, search for **PHP Go!** from the App Store or Google Play. Once downloaded, login using your PHP Member Account credentials. If you do not have a Member Account yet, select "**First Time User?**" once the app is open to begin.

Available on the App Store Get it on Google play

WELLNESS TOOLS: GET PHP FIT!

Take charge of your health; wellness resources at your fingertips.

Get PHP Fit! is the umbrella under which all PHP health and wellness tools reside. If you explore the PHP website, phpni.com, under the Wellness Tools menu item, you'll find many options designed to help you evaluate your health, incorporate behavior changes, and get rewarded along the way. With Get PHP Fit! you'll have the opportunity to learn about good health, meet personal goals, earn incentives, and stay motivated.

Get PHP Fit!

Get PHP Fit is a resource available for our members and includes tools to evaluate overall health with a Health Risk Assessment, educational classes to meet your health goals, and quarterly health challenges for a chance to win prizes.

You can choose to engage in:

Challenges: Challenge yourself with a new health and wellness goal each quarter.

Educational Programs: Receive online health education classes based on your risks identified in the Health Risk Assessment.

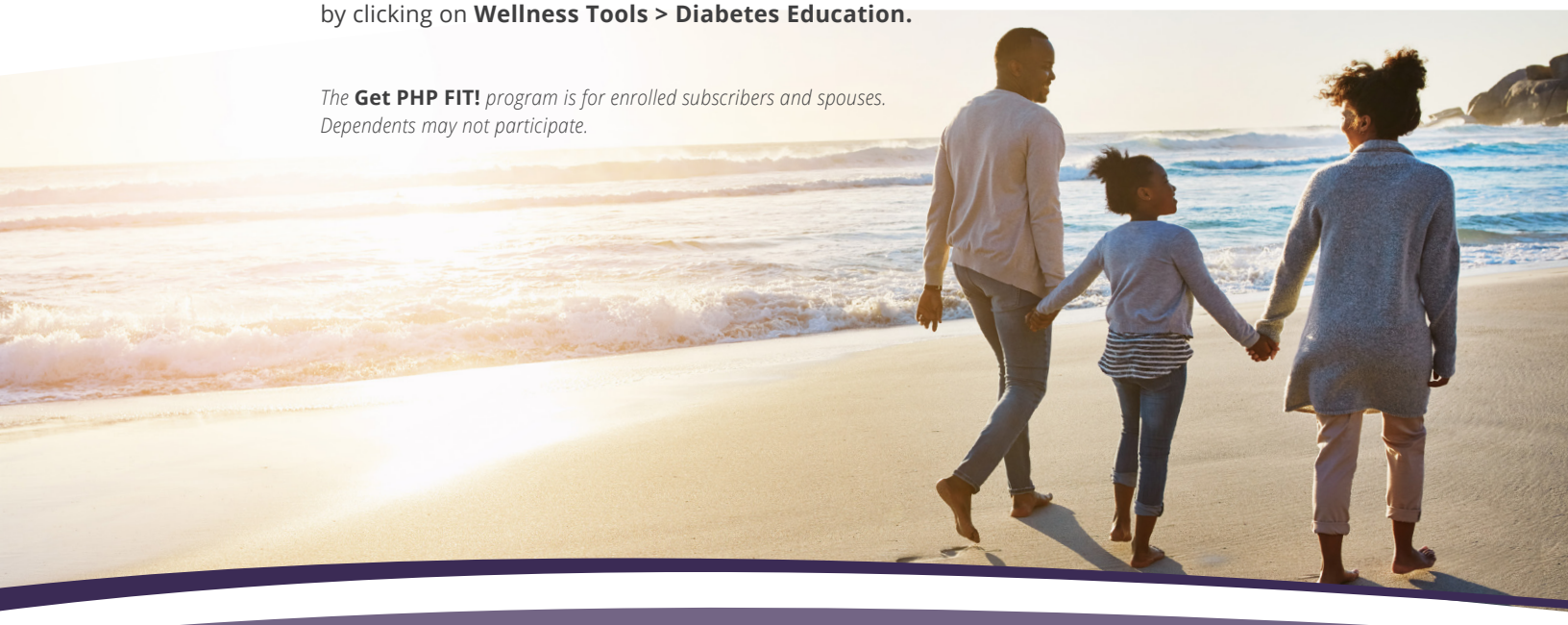
Health Risk Assessment

Your **Get PHP Fit!** Health Risk Assessment (HRA) measures your health risk considering your current nutrition, fitness, lifestyle, and preventive health. Complete your 10-minute assessment and receive a personalized HRA Report showing your health risk by category along with tailored recommendations to improve your health.

Diabetes Education

PHP offers education information to assist our members diagnosed with diabetes and offer encouragement to manage this condition. Information can be found on the PHP website, **phpni.com**, by clicking on **Wellness Tools > Diabetes Education.**

The **Get PHP FIT!** *program is for enrolled subscribers and spouses. Dependents may not participate.*



TELEHEALTH SERVICES

Parkview Employer Solutions Virtual Care is a convenient, no-cost option for quality medical care. PHP members get 24/7 access to a provider through the convenience of video or mobile app visits. Doctors are available around the clock to treat and diagnose many non-emergency health issues. Prescriptions can also be submitted directly to the pharmacy of your choice.

PARKVIEW EMPLOYER SOLUTIONS
VIRTUAL CARE SOLUTIONS

Simple steps to start using this service

Download the MyChart app
Available on both Apple App Store or Google Play under '**MyChart**'.

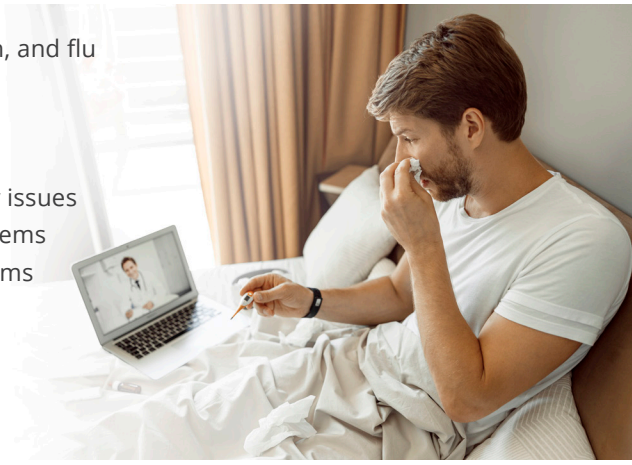
Parkview MyChart account
Login to or create a Parkview MyChart account by visiting MyChart.Parkview.com or by registering on the mobile app.

Start a virtual visit
Launch a virtual visit at Parkview.com/phptelehealth or on the MyChart app by selecting **"PHP Telehealth"** from the menu.

Launch a virtual visit:

Use this service for the following situations:

- Cold, cough, and flu
- Allergies
- Pink eye
- Sore throat
- Respiratory issues
- Sinus problems
- Skin problems
- And more!



MY NURSE 24/7 - A FREE RESOURCE

PHP offers a 24-hour nurseline to answer your healthcare questions any time of the day or night.

Questions about a medication that you are taking or symptoms you might be experiencing can come up at any time. It is nice to have a quick and convenient response to these questions. That is why we offer a 24 hours a day, 7 days a week, and 365 days a year, **MyNurse 24/7** toll-free help line for noncritical situations. This free benefit allows members to speak with experienced, knowledgeable nurses about specific health concerns. In case of an emergency, please call 911.

Medicine or Health Questions + 1-800-931-4714 = MyNurse 24/7

OUT-OF-NETWORK REFERRALS

Seeking Treatment Outside of PHP's Provider Network

If your in-network PHP physician determines that you need to be referred to a specialist that is out of your provider network, your PHP physician must complete and forward a referral request form and documentation supporting the request **prior** to receiving 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.

If you are covered under one of our Point-of-Service (POS) benefit plans, out-of-network benefit coverage is available without a referral. This allows you the choice to receive healthcare services from a non-participating provider however it may be subject to higher out-of-pocket expenses and may be subject to balance billing over your payment amount.

No matter what network or plan you are under, always verify a new providers participation even when referred by an in-network doctor. Feel free to contact PHP Medical Management with any questions regarding out-of-network plan referrals at **260-432-6690, or 1-800-982-6257.**

TREATMENT COST ESTIMATOR

The **Treatment Cost Estimator**—a powerful online tool, helps take the guesswork out of choosing the right treatment provider or facility for you. Use the Treatment Cost Calculator to explore a wide range of health treatment options that help you make a truly informed decision. With the Treatment Cost Estimator, members can research and compare pricing information to make decisions before receiving services, for example:

- Get estimates for hundreds of procedures and services including x-rays and scans, outpatient surgery, office visits, and inpatient admissions.
- Calculate the total cost and break down costs by relevant categories (e.g. facility, professional, and anesthesia), along with what PHP will likely pay and what your expected share of the cost will likely be.
- Locate and compare the cost of a procedure at various facilities in a geographic area.
- Get additional education on annual treatment costs for the most prevalent chronic conditions, information about conditions and procedures, and cost savings tips for saving money on particular procedures.

Login to your *Member Account* at **phpni.com** and click on *Resources* to locate the Treatment Cost Estimator.

MEDICAL TREATMENT CONSENT

Complete this Form and Be Prepared When You Travel

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 or caregiver 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

1. Child's full name _____ Date of birth_____
Child's physician and phone number _____
Important medical history (chronic conditions, allergies, reactions, etc.) _____
_____

2. Child's full name _____ Date of birth _____
Child's physician and phone number _____
Important medical history (chronic conditions, allergies, reactions, etc.) _____
_____

3. Child's full name _____ Date of birth _____
Child's physician and 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 _____

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 into your *Member Account* and clicking the *Resources* menu where the form is located. Download the printable PDF version. Having this form prepared in advance of travel could save your child's life.

A CHECKLIST: ASK YOUR DOCTOR

Guidelines to Organize your Visit

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: *Am I getting better or worse?*

GETTING THE MOST FROM YOUR DOCTOR VISIT

Tips for managing your health:

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

Tip 1: Take 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 and 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 a record (print or electronic) in a file.

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.
- 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 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 for unfamiliar terms, as well as proper spellings and meanings. Take written information home with you to help 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/appointment with a specialist), even after you start to feel better. If you are confused or if you have forgotten something, it's okay to contact your doctor; call the office and ask to leave a message with the doctor or to speak with a nurse. Don't hesitate to contact your doctor when:

- You have any questions after the appointment.
- You start to feel worse or have problems with your medication.
- You've had lab or other tests but have not yet received test results.

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 PHP > Benefits and Contracts,** to view complete account information.

COORDINATE BENEFITS WITH MULTIPLE PLANS

What if I'm covered by more than one health plan?

Coordination of Benefits (COB) is the method used to process a claim when a member has more than one insurance plan. In this case, the primary plan will make payment and the amount that is left is then considered by the other plan.

Can I choose which carrier (insurance company) I want to pay as primary?

No, you cannot choose your primary carrier. Several different types of *Coordination of Benefit* rules will determine which carrier will be the primary payer.

What do I do if I have more than one carrier?

If you are covered by more than one carrier, you need to contact all of the carriers involved so they will know how they need to coordinate payment on your claims. To notify PHP of other insurance information or changes, please call PHP Customer Service.

Does being eligible for Medicare Part B affect my PHP coverage?

When you become Medicare Part B eligible and Medicare is the primary coverage, the PHP policy will coordinate your PHP coverage and Medicare Part B coverage, beginning on your date of Medicare eligibility and regardless of whether you enroll in Medicare or not. **You may wish to enroll in Medicare once you are eligible to avoid unplanned medical expenses.**

WORK AND ACCIDENT-RELATED CLAIMS

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?

Prior to 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 benefits policy. Items that may not be covered in a health benefits policy include the following:

- Treatment that is not medically necessary, such as cosmetic procedures
- Investigational or experimental treatments
- Medical treatment as a result of a third-party liability
- Medical treatment resulting from illegal activity or while driving under the influence of an intoxicant
- Charges for a course of treatment discontinued against medical advice

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 PHP Customer Service.

DEPENDENTS: COLLEGE-BOUND STUDENTS

PHP realizes that not all dependent college students attend college in our service area. That is why PHP and your employer are committed to getting students the coverage and care they need. Simply let us know when you have a dependent student living out of the service area and we will take it from there to keep their care and coverage going. You can call, email, or submit a quick form at **phpni.com/students.**

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

HIPAA INFORMATION FOR MEMBERS

HIPAA Privacy Act Notice

PHP's *HIPAA Privacy information* can be accessed on the member account at **phpni.com > My PHP > Benefits and Contracts > View HIPAA Privacy Notice.**

A downloadable *HIPAA Authorization Form* is available on page 36 of this handbook or online in your member account: **Resources > Forms > Authorization for Use and Disclosure of Protected Health Information**

PHP recognizes the importance of privacy and security of member health information. We have developed a strong corporate HIPAA compliance strategy incorporating actions and processes needed to ensure that our operations are in compliance with all HIPAA regulations.

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. Group health plans sponsored by employers and insurers are obligated to comply with HIPAA.

HIPAA contains two main provisions:

- **Portability:** A U.S. employee's legal right to maintain certain benefits when switching employers or leaving the workforce.
- **Administrative Simplification:** The Patient Protection and Affordable Care Act works to standardize operating rules and reduce the amount of paperwork for doctors and patients.

PHP AND YOUR PERSONAL HEALTH INFORMATION (PHI)

Prior to releasing PHI a PHP customer service representative must verify information about the person requesting information. The following information will need to be verified:

1. Member name and PHP Identification number and/or social security number
2. Date of birth; confirming member's age
3. Designated representative *(Does PHP have a designed representative or signed consent file for this person?)*

Q **What information can be released when a designated representative and/or consent form are actively on file with PHP?**

A All information about a member can be released as outlined in accordance with the members signed and active consent form on file at PHP. Members can exclude certain types of information from being released on the consent form, such as behavorial health, communicable disease, and drug or alcohol use.

APPEALS AND GRIEVANCES

The Appeals Process

PHP prides ourself on outstanding customer service. We provide consistent service to our members 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 *Grievance and Appeal Coordinator* to assist you throughout the process. Your *Certificate of Coverage* provides a full outline of the appeal and grievance procedure.

Following is a summary of the process:

- 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 attention of the

Grievance and Appeal Coordinator at:
260-432-6690, (1-800-982-6257)

Mailing Address:
Grievance and Appeal Coordinator
Physicians Health Plan, 1700 Magnavox Way, Suite 201
Fort Wayne, IN 46804

- You will receive an acknowledgment letter from PHP that will outline the process and time frames for completion.
- Your Grievance and Appeal Coordinator will represent your grievance to a Grievance Committee. The Grievance Committee decision will be communicated to you in writing
- If you disagree with the decision made by the Grievance Committee, you may submit a request for reconsideration (appeal). The Grievance and Appeal Coordinator will forward your request to a third party reviewer. A summary of the discussion and decision of the panel will be communicated to you in writing.
- If you disagree with the appeal decision made by the panel and your denial was based upon a medical judgment decision such as investigational or experimental treatment; 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.

Notice of Benefits under the Women's Health and Cancer Rights Act of 1998

In accordance with the *Women's Health and Cancer Rights Act of 1998*, PHP must provide benefits to a covered person for certain services relating to a mastectomy.

If a covered person receives medical and surgical benefits in connection with a mastectomy and elects breast reconstruction, PHP will provide coverage for eligible expenses incurred for the following services and supplies:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to provide a symmetrical appearance
- Prosthesis
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas

Coverage will be:

- Provided in a manner determined in consultation with the patient and the attending physician
- Subject to copays, coinsurance, and any deductibles that are applicable to similar benefits under your benefit plan
- Provided to current members regardless of whether the person was covered under the plan during the mastectomy

FRAUD AND ABUSE

Medical Identity Fraud

While you're having a new prescription filled, your pharmacist says your new drug conflicts with another medication your records show you take. But you aren't taking that medication. Or maybe on a recent bill you see a charge for a mysterious medical item.

You could be the victim of medical identity fraud. This new type of identity theft happens when someone steals your medical information and uses it to get medical products, treatment, or services. If you're a victim, your medical records can contain mistakes. These mistakes could hurt your ability to get needed care.

Fraud and Abuse are Illegal

Fraud and abuse are illegal. You can report suspected fraud by calling **PHP Customer Service: 260-432-6690, or 1-800-982-6257.**

Detecting Medical Identity Theft

If you suspect that your medical identity has been stolen, take these steps:

- Look over all *Explanation of Benefits (EOB)* forms from PHP. Do this even if you owe nothing. If anything seems wrong, contact PHP.
- Once a year, PHP provides an annual statementof benefits of all claim activity in your name. Review this document carefully, looking for any care you did not receive.
- Check your credit reports for suspicious medical debts. You can get a free yearly credit report from each of the three consumer reporting companies.

1-877-322-8228 or visit annualcreditreport.com.

You also can ask for copies of your current medical files from your health providers. You should get them within 30 days.

Protecting Your Medical Identity

To protect your medical identity, it's your right and responsibility to:

- Learn where your medical information has been sent. For example, if you move or switch insurers, your records may have gone to several new doctors or hospitals.
- Get wrong or incomplete information removed from your files.
- Have correct information added.

Today, the Internet carries more and more personal health information. So remember to keep your name, Social Security number, credit card accounts, and health insurance information to yourself. Share your personal medical information only with doctors and other health workers.

Reporting Fraud and Abuse

If something sounds too good to be true, it probably is. Remember to check your bill closely, guard your ID information, and avoid people who promise to get insurance to cover services that are not normally covered.

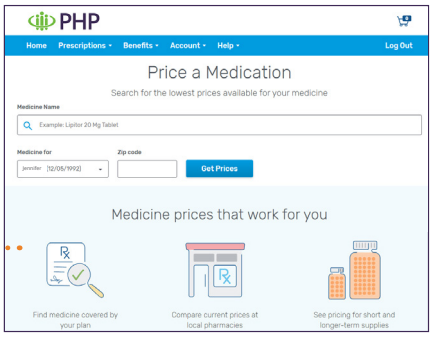
USING PHARMACY BENEFITS

Steps to Save on Your Prescriptions – Stop and Compare!

1 Use generic drugs, whenever possible.

2 Mail order can be a cost-effective solution. Log in to your member account at **phpni.com** and select **Pharmacy > My Pharmacy Services**. Once there select '**Refill Prescriptions**' to see what you could save.

3 **Stop and Compare:** Many times, drug prices vary from one retail location to another. Remember to check each time you refill a prescription, as the cheapest location can change from month to month. To make it easier for you, we have a pricing tool available in your member account. To get started log in and go to: **Pharmacy > Price a Medication**.



Pharmacy Website Access

PHP understands how important it is for you to have access to information about your pharmacy services. Simply login as a PHP Member at **phpni.com** and select Pharmacy from the left hand menu for access to a variety of pharmacy information.

The Pharmacy menu gives you access to the following features:

- Pharmacy Benefits
- Drug Listings
- My Pharmacy Services
- Pharmacy Claims
- Price a Medication
- Save on Prescriptions

Selecting the **My Pharmacy Services** menu option will direct you to your online pharmacy account *(through our vendor partner website)*, giving you access to the following features and information:

- My Medications
- Order History
- Claims and Balances
- Price a Medication
- Automatic Refills
- Find a Pharmacy
- Pharmacy Options
- Prior Authorization
- Request an RX

Tips for registering online:

- 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.

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 seven levels of prescription drug coverage. These seven levels are described in the table below.

What is a tiered copayment pharmacy benefit and how does it work?

A tiered copayment benefit means there are several possible copayment levels. A member's copayment is based on the prescription drug being purchased. For example, the first tier represents a preferred generic drug that has the lowest copayment.

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.

Traditional Drugs

Tier 1:	**Preferred Generic:** Covered drugs that are no longer protected by a drug company patent allowing other drug companies to create equivalent versions of the same drug at a reduced cost.
Tier 2:	**Non-Preferred Generic:** Similar to Tier 1 covered drugs, but available with a higher copay.
Tier 3:	**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.
Tier 4:	**Brand Non-Formulary:** Covered drugs that are not included in the formulary listing. You may obtain nonformulary brand-name drugs with a higher pharmacy copayment.
Tier 5:	**Specialty Drugs:** Specialty drugs are generally injectable, high-cost medications, which you may obtain through our specialty pharmacy, unless administered by a PHP network provider.

Specialty Drugs

Tier 1:	**Preferred Specialty Drugs:** These medications can be injectables or orals that are extremely expensive, must be filled at specialty pharmacy, and may need special instructions and handling.
Tier 2:	**Specialty Drugs:** These medications can be injectables or orals that are extremely expensive, must be filled at specialty pharmacy, and may need special instructions and handling.

MAXIMIZE YOUR BENEFITS

Sometimes it's possible to swap your prescription for an over-the-counter drug, a great way to save dollars. Staying on top of need-to-know prescription information can save you money and also save your life — or the life of someone you love. Take charge of your medications!

FREQUENTLY ASKED PHARMACY QUESTIONS

Ways to save on pharmacy costs.

Understanding your pharmacy benefit and how it works can save you money next time you head to the pharmacy. Here are some quick tips to help you save:

Stop and Compare drug pricing from location to location as prices can change monthly.

Swap your prescriptions for over-the-counter drugs, if possible.

Use generic drugs, whenever possible.

Try mail order, it can save you money and time.

What is a formulary?

A formulary is a list of prescription drugs that PHP encourages our doctors to prescribe when appropriate. The formulary is 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 copayment or to ask your doctor for a formulary medication. Refer to your certificate of coverage for the generic, formulary and non-formulary copayment amounts that apply to your benefit plan.

Where can I get drug formulary information?

Our Customer Service Department can provide drug formulary information, or you may download a copy of our formulary on our website at **phpni.com.**

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, development, and advertising 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* (PA). If your doctor wants to prescribe a PA 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.*

How do I submit a claim for a prescription if I used a discount card like GoodRX?

We are often asked, if there is a better price through Good Rx or another discount card, can that be used instead of the PHP benefit? The answer is yes, and you can get credit toward your out of pocket or deductible for it too by visiting **phpni.com** and submitting the receipt within 90 days of purchase.

To submit the receipt through **phpni.com** go to **Pharmacy > My Pharmacy Services**. From there click **Benefits > Forms**, then scroll down to '**Start a Claim**'. Be sure to have a picture of the receipt from the pharmacy ready to upload.

Can I use a low cost pharmacy like *Mark Cuban's Cost Plus Drugs* if I find a better price there?

Yes. If you find a better price at a low cost pharmacy like *Cost Plus Drugs* you can email your pharmacy receipt to **custsvc@phpni.com** within 90 days for reimbursement or credit toward your out-of-pocket or deductible.

PHARMACY QUESTIONS, continued

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 or pharmacist prior to tablet splitting.

Are there limits on the amount that can be dispensed?

Some medications may be subject to *Quantity Level Limits (QLL)* based on the manufacturer's packaging insert. These limits are designated in the *Drug Formulary* by (QLL) 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 therapeutically indicated medication regimens.

Is prescription mail order service available?

Yes, PHP partners with Express Scripts Pharmacy®, a pharmacy benefit management (PBM) organization that provides integrated pharmacy benefits including delivery that includes fast and convenient delivery of maintenance medications directly to your home up to a 90-day supply. You only pay the copayments as determined by your benefit plan, just as if you were receiving a prescription filled at the local pharmacy. Express Scripts can be reached at **1-866-544-7895** or go to the member portal at **phpni.com**. Click on **Pharmacy > My Pharmacy services**. To obtain a mail order form or for information about the mail order program, please contact PHP Customer Service.

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 Walmart 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 online?

At our site, **phpni.com,** you can refill prescriptions and check for possible drug interactions. You can also download the Express Scripts application for your smart phone.

How can I lower my costs and save money?

By understanding your pharmacy benefit and how it works, you can save money the next time you head to the pharmacy. Try to swap your prescriptions for over-the-counter drugs, use generic drugs, try mail order, or stop and compare drug pricing from location to location to ensure you're getting the best deal for your money.

Where can I find additional information on prescription drug benefits?

For more information call PHP Customer Service. Or for a complete listing of the pharmacy providers in our service area, go to **phpni.com** and select '**Find Care**'.

Can I use a copay assistance program or discount card?

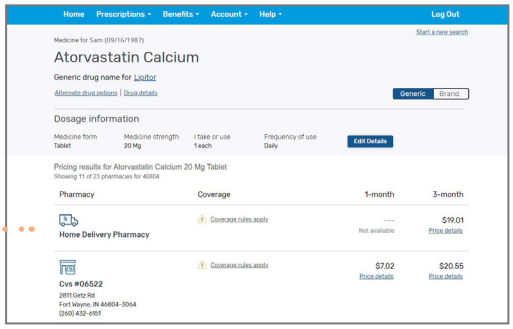
Yes, but members are required under their contract to pay the applicable cost sharing, which includes the Deductible, Copay, or Coinsurance as shown on the Schedule of Benefits. The requirement to pay the applicable cost sharing (Deductible, Copay, or Coinsurance) cannot be waived by a provider, a pharmacy or anyone under any "fee forgiveness", "not out-of-pocket", "discount program", "coupon program" or similar arrangement. If a provider, pharmacy or third party (other than family) waives, discounts, reduces, or indirectly pays the required cost sharing (Deductible, Copays, or Coinsurance) for a particular claim, the applicable cost sharing met by the member on the claim will be reduced to reflect the amount of such waiver, discount, reduction or third party payment. The total amount accumulated toward any overall deductible and/or maximum out-of-pocket amounts will also be reduced by the amount of any discount.

MORE ON PHARMACY COSTS

Use the **Price a Medication** tool before you go to the pharmacy

Many times, drug prices vary from one retail location to another. Remember to check each time you refill a prescription, as the cheapest location can change from month to month.

To make it easier for you, we have a pricing tool available in your member account. Log on and go to **Pharmacy > Price a Medication**. From there you can compare medications from various locations, and see 1-month vs. 3-month supplies.



Learn more about specialty drugs

What are specialty drugs?

Specialty drugs are generally high-cost medications that have special handling requirements or require special training before use.

How do I obtain specialty drugs?

These types of medications may be obtained through our specialty pharmacy, unless administered by a participating PHP network provider.

What is Accredo?

Accredo is a specialty pharmacy that serves patients with complex and chronic health conditions.

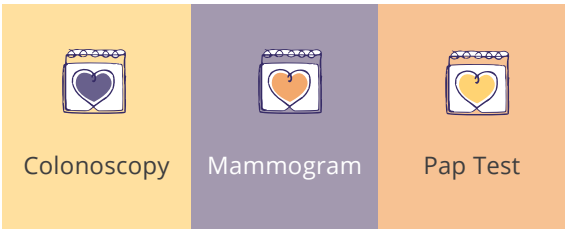
PREVENTIVE EXAMS AND SCREENINGS

The Centers for Disease Control and Vaccinations

Vaccination is one of the best ways parents can protect infants, children and teens from 16 potentially harmful diseases. Vaccine-preventable diseases can be very serious, may require hospitalization, or even be deadly - especially in infants and young children.

Immunizations are not just for children. Protection from some childhood vaccines can wear off over time. Adults may be at risk for vaccine-preventable disease due to age, job, lifestyle, travel, or health conditions. Check with your healthcare provider for more information.

Take advantage of free services under your plan! **Most preventive services are available to you free of charge with no out-of-pocket fees.** Schedule an appointment with your doctor to get caught up on your health screenings:



Why are preventive services important?

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.

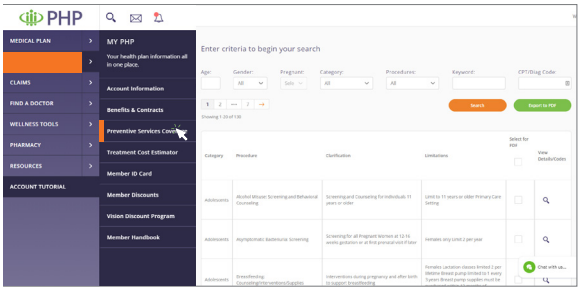
PHP covers a comprehensive range of preventive care services for adults, women, and children including the preventive services recommended under the *Patient Protection and Affordable Care Act* (Affordable Care Act) and the comprehensive guidelines supported by the *Health Resources and Services Administration ("HRSA")*.

Be sure to talk with your personal healthcare provider to determine what procedures they would recommend for you and your family.

What preventive services are available for free?

Always use the preventive services search tools available at phpni.com.

To find what services are available, log on to your member account at **phpni.com**, and go to **My PHP > Preventive Services Coverage**. From there you can search covered services by category *(adults, adolescents, pediatric, pharmacy, etc.)*, keyword, diagnosis code, or by procedure.



Complete immunization information at **cdc.gov/vaccines**

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 must all continue to follow vaccination guidelines for the health of our communities. **Vaccination schedules** can be found at: **cdc.gov/vaccines.**

MANAGING YOUR CARE

One of the benefits of being a member of PHP is the personal care and attention you receive from our staff. We understand the challenges of navigating through the healthcare system, especially when you or a loved one has a serious illness or a need for complex care. When this happens, our experienced care managers are there to help.

Our care managers develop individual plans of care, working as a team with members and their families, doctors, nurses and other providers of health services. These care plans are made to:

- Educate and empower members to make informed decisions about their healthcare
- Coordinate care among multiple providers and services
- Treat each person as an individual, with unique goals and challenges that sometimes change
- Address each member holistically with physical, psychological, and social needs
- Link members to community agencies and services that can assist them
- Increase member understanding of his or her plan of treatment
- Assist members and their families with setting and reaching goals that are important to them
- Maximize member self-care
- Improve each member's health and quality of life

At PHP, we believe that educated members who actively participate in their care have the best chance of improving their health. When you have a complex or chronic condition, we'll be there to support you, smoothing your way through the healthcare system and getting you on the road to optimum health.

PHP TOBACCO CESSATION OPTIONS

Quitting tobacco is not easy, but it can be done. Whether you're a smoker, someone who uses smokeless tobacco, or someone trying to help a friend or loved one, PHP offers a variety of options to help members who want to quit their addiction to tobacco.

PHP understands that quitting is NOT easy

Stopping or cutting back on tobacco causes symptoms of nicotine withdrawal. Withdrawal is both physical and mental. Physically, your body is reacting to the absence of nicotine. Mentally, you are faced with giving up a habit, which calls for a major change in behavior.

PHP covers the following FDA-Approved Tobacco Cessation Medications:

- Nicotine Patch
- Nicotine Lozenge
- Nicotine Inhaler
- Varenicline (CHANTIXTM)
- Nicotine Gum
- Nicotine Nasal Spray
- Bupropion (ZybanTM)

For all of the above:

- Must have a prescription for up to 30 days of medication for coverage at 100%.
- Two 90-day Tobacco Cessation treatment regimens per year* covered at 100%.

**A year is a rolling 365-day period, not a calendar year.*

For more information on PHP's Tobacco Cessation resources visit **phpni.com > Tobacco Cessation** or contact the Indiana and Ohio Tobacco Quitline at **800-QUIT-NOW (800-784-8669)** or their websites **quitnowIndiana.com** or **ohio.quitlogix.org**.

PHP VISION PROGRAM AND DISCOUNTS

PHP partners with VSP Vision Care, the only national not-for-profit vision care company, to provide members significant discounts on well vision exams, prescription and/or non-prescription glasses, frames, contact lenses, and laser vision corrective services at VSP provider locations.

How does the PHP-VSP Discount Program work?

Features of VSP service providers:

- No claim forms to fill out and no waiting for reimbursement
- Present your PHP ID card at one of the many participating offices
- VSP discount benefits may be used as often as you like, with no limit to your savings

Who is eligible?

- The VSP Discount Program is available to all PHP members, included automatically with their medical coverage.

Thousands of Locations

- VSP has nearly 50,000 access points nationwide. To find a VSP doctor near you, visit **vsp.com/choice** and enter your zip code or address to begin the search.

Vision Care Services	Discount
Well Vision Exam Focuses on your eye health and overall wellness	**20% discount** off doctor's fee
Lenses Discount Prescription or non-prescription glasses, when a complete pair of glasses is purchased. Applies to lens options such as progressives, scratch resistant, and anti-reflective coatings.	**20% discount**
Frames Discount With a complete pair of glasses purchase.	**20% discount**
Contact Lens Exam Discount on exam, including fitting and evaluation *(Exclusive offers for VSP members, including mail-in rebates on select brands.)*	**15% off exam**
Laser Vision Correction	Average of **15% off** regular price or **5% off** promotional prices

PHP's Vision Discount Program with VSP Vision Care

Save on eye exams, frames, lenses, and laser vision correction services

VSP® Vision Care

For complete details on the PHP's vision discount program, please contact: VSP at: vsp.com or call, VSP Customer Service: 1-800-877-7195

ADVANTAGES OF PHP

Discounts at Health Clubs and Community Classes

PHP gives our members tools and information to help them meet their personal health and fitness goals. 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:

- Free trial memberships or discounts on annual memberships
- Discounts on activity and enrollment fees, and training packages

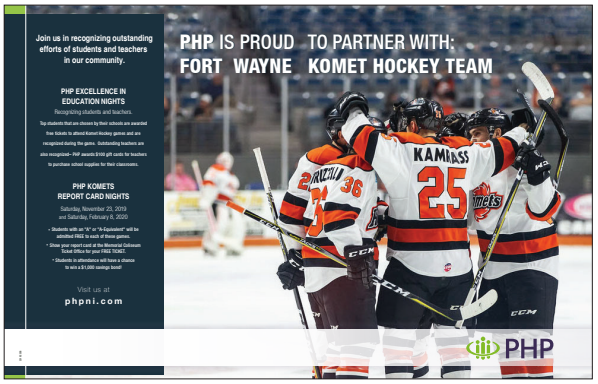
To learn more about these programs and for a list of participating health clubs and resource centers, visit **phpni.com;** look for **Member Discounts** in the site map.

PHP - Employee Benefit Solutions on Social Media

Follow us on Facebook, Instagram, and Youtube under the handle **@phpni** to learn more about PHP, our investment in the community, tips on how to stay healthy and active, and how to make the most of your benefits. PHP posts notifications and reminders about preventive benefits and wellness initiatives to help you control your healthcare costs and care for yourself at the same time.

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 and Fort Wayne TinCaps. Our *PHP 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 *PHP Card Night.* Discounts vary by team. Discounts are found at **phpni.com** under **Member Discounts** in the site map.



DON'T SPEAK INSURANCE? THIS GLOSSARY MAY HELP!

The following glossary of terms is intended to be used only as a general reference guide to help you better understand the terminology used in the healthcare industry. This is 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 (revoking) of coverage.

Allowed Amount: Maximum amount on which payment is based for covered healthcare 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 non-hospital 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 health insurance company.

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

Authorization: Process by which the insurance company approves high-dollar, complicated, or unusual medical services or out-of-network requests.

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 a 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.

Clinic/Retail Clinic: A category of walk-in clinic located in retail stores, supermarkets and pharmacies that treat uncomplicated minor illnesses and provide preventative healthcare services. They are sometimes called "retail clinics," "retail-based clinics," "walk-in medical clinics," or "nurse-in-a-box." These clinics are usually staffed by nurse practitioners (NPs) or physician assistants (PAs) and do not necessarily have a doctor available. Some clinics, however, are staffed by physicians.

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 healthcare 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 mother or the fetus. Morning sickness and non-emergency cesarean 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 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 healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

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

Coverage or Covered: The fact that the healthcare 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 healthcare 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 healthcare services subject to thedeductible. 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 website at **phpni.com**.

Durable Medical Equipment (DME): Equipment and supplies ordered by a healthcare 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 services received in an emergency room of a hospital or facility.

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.

Essential Health Benefits: Under the Affordable Care Act, a set of healthcare service categories that must be covered by certain plans. The ten categories include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Excluded Services: Healthcare 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/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.

High Deductible Health Plan (HDHP): 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: Healthcare 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 healthcare 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)*: Federal law that established portability and administrative simplification requirements for health plans and issuers of health coverage.

Home Health Care: Healthcare 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.

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

In-network Co-insurance: The percentage (for example 20%) you pay of the allowed amount for covered healthcare 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 healthcare 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 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: Maximum amount of benefits payable for a given situation or occurrence, e.g., 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.

Maximum Out-of-Pocket (MOOP): Most you pay during a policy period before your health plan pays 100% of Allowed charges. This amount does not include premiums, balance-billed charges, or services not covered by your plan. Your plan may not include copayments or other out-of-network charges.

Medically Necessary: Healthcare 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.

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

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 as Health Care Reform or the Affordable Care Act (ACA). This 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: Healthcare 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 healthcare services.

Policy Year: The period between policy anniversary dates.

Preauthorization/Prior Authorization: A decision by your health insurer or plan that a healthcare 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.

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. You may have preferred providers who are also "participating" providers. Participating providers 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.

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 healthcare services.

Primary Plan/Secondary Plan: Primary plan includes benefits that 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 employer's 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), healthcare professional or healthcare facility licensed , certified or accredited by by state law.

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

Qualified Payment Amount (QPA): The median contracted rate for a specific service and specialty in a geographic region, network, and market. It determines payment amounts for certain out-of-network medical bills and protects members from balance billing, helping to keep costs low and avoid unexpected charges. (Part of the Federal No Surprise Act).

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: Healthcare 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.

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.

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 healthcare.

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 whose employment is the basis for membership.

Subsidized Coverage: Health coverage that is obtained through financial assistance from programs to help people with low and middle incomes.

Summary of Benefits and Coverage (SBC): A short, easy-to-understand document provided to consumers that summarizes the key features of the plan or coverage they are considering or that they currently have.

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 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.

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

YOUR MEMBER HANDBOOK

This handbook is a general summary of the benefits and programs offered by PHP. Please refer to your *Certificate of Coverage (COC) and sponsor Contract* which set forth the benefits provided under your insurance plan, as well as limitations and exclusions. To view or print your contract materials including your *Certificate of Coverage, HIPAA Privacy Notic*e, and *Summary of Benefits and Coverage (SBC)* login to **phpni.com** and select the **My PHP** from the menu. You will find account information, benefits and contracts, preventive services coverage, member ID cards, discounts, and a copy of the PHP member handbook here. In the event of a conflict, the Certificate of Coverage and Contract control.

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

1700 Magnavox Way, Suite 201 I Fort Wayne, IN 46804

260-432-6690 I 800-982-6257

For Ohio Members: *Coverage issued by Physicians Health Plan of Northern Indiana, Inc., and PHP Insurance Company of Indiana, Inc. provides for out-of-network benefits.*

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