HealthChoice Declarations Page

Welcome to PHP! This page identifies information unique to your Group Coverage. Please review this information carefully. The HealthChoice Contract contains binding provisions granting and excluding benefits and Coverages, defining terminology and specifying limitations and conditions. This declarations page shall be attached to and is made a part of the Contract.

The Contract is executed between PHP and [Name of Group] (the Group).

Benefit Plan Name: [Benefit Plan Name]

Effective Date of Contract/Coverage: [mm/dd/yyyy]

The General Exclusions section of the Contract shall also include the following Exclusion:

Bariatric surgery, including but not limited to:

A. gastric bypass surgery;
B. surgical procedures that reduce stomach capacity;
C. gastric banding procedures; and
D. complications as a result of bariatric surgery.

The Eligibility section of the Contract shall also include the following:

Spousal Coverage

If both spouses are Eligible Persons, each may enroll as a Subscriber and enroll the other spouse and any eligible Dependents for Coverage under the Contract. In this situation, the combined maximum benefits per Member may not exceed 100% of Eligible Expenses.

Our Customer Service Department is available to answer questions you may have. You may contact PHP's Customer Service Department at: (260) 432-6690, Extension 11; (800) 982-6257, Extension 11; (260) 432-0493 (fax); custsvc@phpni.com (email); or www.phpni.com.

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Authorized PHP Representative

Amendment

Physicians Health Plan of Northern Indiana, Inc. and PHP Insurance Company of Indiana, Inc.

1700 Magnavox Way, Suite 201
Fort Wayne, Indiana 46804

This Amendment is part of the Certificate of Coverage issued by Physicians Health Plan of Northern Indiana, Inc. and PHP Insurance Company of Indiana, Inc. to Subscribers Covered under the HealthChoice Contract issued to [Name of Group] for Benefit Plan Name [Legacy 1000 POS 1 OH]. This Amendment is effective [mm/dd/yyyy].

The Foreword is hereby modified by changing the following language:

No Surprises Act

If you receive care from an out-of-network Provider or facility, your health plan may not Cover the entire cost. As a result, you may be left with higher costs than if you received care from an in-network Provider or facility. In the past, in addition to any out-of-network cost sharing you may owe, the out-of-network Provider or facility could bill you for the part of the bill that your health plan did not pay, resulting in a balance bill. An unexpected balance bill from an out-of-network Provider or facility is also called a surprise medical bill.

Starting in January 2022, new rules went into effect to protect you from surprise medical bills. These rules are sometimes called the "No Surprises" rules. These rules:

- Ban surprise medical bills for Emergency services, even if you get them out-of-network and without approval beforehand (Prior Authorization).
- Ban out-of-network cost-sharing (like out-of-network Coinsurance or Copayment) for all Emergency and some non-Emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network cost-sharing (like out-of-network Coinsurance or copayment) for all air ambulance transportation services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for supplemental care (like anesthesiology or radiology) by out-of-network Providers who work at an in-network facility.
- Require that health care Providers and facilities give you an easy-to-understand notice explaining that getting care out-of-network could be more expensive and options to avoid balance bills. You're not required to sign this notice or get care out-of-network.
- Provide that if you meet the criteria of a continuity of care patient and are currently receiving treatment for Covered Health Services from a Provider that has a network status change from in-network to out-of-network during your treatment and the Provider terminates, you may be eligible to request continued care from your current Provider under the same provisions that would have applied prior to termination. This provision would not apply to Provider terminations due to fraud or failure to meet quality standards. To see if you are eligible for continued care under this provision, please contact us.

Also starting in January 2022, if you think your health plan's decision to not pay part or all of a claim violates the new surprise billing protections, you can Appeal that decision. You can use the external review process described in the plan document and denial notices to request the external review of your plan's decision to determine if your claim is subject to the No Surprises Act. If a claim is subject to the No Surprises Act, the Provider and PHP will follow the federal regulations to resolve any differences over the payment amount. This policy will be administered in accordance with the No Surprises Act and applicable regulations and, to the extent any provision of the Policy conflicts, the law will govern.

Amendment

If you have a question about these new rules or believe the rules are not being followed, contact the "No Surprises" Health Desk at 1-800-985-3059 or submit a complaint online at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

The Coordination of Benefits Section of the Certificate of Coverage is hereby modified by deleting the following section:

Medicare Eligibility

The remainder of the Certificate of Coverage remains unchanged.

This Amendment does not alter or affect any of the terms, conditions, exclusions or limitations of the Contract, other than as stated above. If the provisions of this Amendment and those of the Contract do not agree, the provisions of this Amendment shall govern.

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Authorized PHP Representative

Amendment

Physicians Health Plan of Northern Indiana, Inc. and PHP Insurance Company of Indiana, Inc.

1700 Magnavox Way, Suite 201
Fort Wayne, Indiana 46804

This Amendment is part of the Certificate of Coverage issued by Physicians Health Plan of Northern Indiana, Inc. and PHP Insurance Company of Indiana, Inc. to Subscribers Covered under the HealthChoice Contract. This Amendment is effective [1/1/2026].

The Schedule of Benefits is amended as follows:

A. Under Medical Benefits, the following is added:

	In-Network You Pay	**Out-of-Network* You Pay**
Hearing Aids and Related Services		
Hearing Aids Limited to one per ear up to $2,500 every 48 months if under age 22 and are deaf or hearing impaired. If you purchase a Hearing Aid over $2500, you are responsible for paying the price difference. This benefit applies whether new purchase, replacement or repair.	One per ear, up to $2500 every 48 months	One per ear, up to $2500 every 48 months
Hearing Aids and Related Services	0% [Deductible does not apply.] [For High Deductible Health Plans, the Deductible applies.] [The [Total] Out-of-Pocket Limit applies.]	0% [Deductible does not apply.] [For High Deductible Health Plans, the Deductible applies.] [The [Total] Out-of-Pocket Limit applies.]

B. Under Medical Benefits - Therapy and Other Practitioner Visits - Chiropractor Services, the following is revised:

	In-Network You Pay	**Out-of-Network* You Pay**
Other Practitioner Visits Chiropractor services are limited to 12 visits combined In-Network and Out-of-Network per Calendar Year across outpatient and other professional visits.	[0%-50%] [after Deductible.] [The [Total] Out-of-Pocket Limit applies.]**	[20%-50%] [after Deductible.] [The [Total] Out-of-Pocket Limit applies.]**
Outpatient Therapy Services - Rehabilitation Services Combined In-Network and Out-of-Network limit per Calendar Year: - Physical therapy: 40 visits - Occupational therapy: 40 visits - Speech therapy: 40 visits - Cardiac Rehabilitation: 36 visits - Pulmonary Rehabilitation: 20 visits	[0%-50%] [after Deductible.] [The [Total] Out-of-Pocket Limit applies.]**	[20%-50%] [after Deductible.] [The [Total] Out-of-Pocket Limit applies.]**
Outpatient Therapy Services - Habilitation Services Combined In-Network and Out-of-Network	[0%-50%] [after Deductible.] [The [Total] Out-of-Pocket Limit applies.]**	[20%-50%] [after Deductible.] [The [Total] Out-of-Pocket Limit applies.]**

limit per Calendar Year: - Physical therapy: 40 visits - Occupational therapy: 40 visits - Speech therapy: 40 visits		

**** All services listed under Out-of-Network are subject to Reasonable and Customary Charges, except for Out-of-Network Emergency benefits.***

*****The cost share you pay for services rendered by an occupational therapist, physical therapist or chiropractor shall be no greater than the cost share you pay for a primary care Doctor's office visit.***

The Benefits and Services Section of the Certificate of Coverage is hereby modified by adding the following language:

Hearing Aids (for Covered Persons under Age 22)

We will Cover one Hearing Aid per ear that is medically appropriate every forty-eight months up to $2500 for members under age 22 who are verified as being deaf or hearing impaired by a licensed audiologist or by an otolaryngologist or other licensed physician. We will not Cover the cost of the Hearing Aids if less than forty-eight months prior to the date of the claim the Covered Person received the coverage through another health plan.

We will also cover Related Services prescribed by an otolaryngologist or recommended by a licensed audiologist and dispensed by a licensed audiologist, a licensed Hearing Aid dealer or fitter, or an otolaryngologist.

For purposes of this Coverage, the following definitions apply:

Hearing Aids. Means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and parts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist.

Related Services. Means services necessary to assess, select, and appropriately adjust or fit a hearing aid, to ensure optimal performance.

A Covered Person may choose a higher priced Hearing Aid and may pay the difference in cost above the benefit maximum stated in the Schedule of Benefits, without any financial or contractual penalty to the Covered Person or to the Provider of the Hearing Aid.

Coverage is provided for Hearing Aids that are considered medically appropriate to meet the needs of the Covered Person, according to the professional standards established by the state speech and hearing professionals' board.

The General Exclusions Section of the Certificate of Coverage is hereby modified by changing the following language:

13. Hearing Aids and their fitting with the exception of those under age 22 who are verified as being deaf or hearing impaired and meet the criteria as described in the Benefits and Services Section - Hearing Aids.

Amendment

The remainder of the Certificate of Coverage remains unchanged.

This Amendment does not alter or affect any of the terms, conditions, exclusions or limitations of the Contract, other than as stated above. If the provisions of this Amendment and those of the Contract do not agree, the provisions of this Amendment shall govern.

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Authorized PHP Representative

HealthChoice Certificate of Coverage

(Certificate)

issued by

An Ohio Not-for-Profit Health Insuring Corporation

Physicians Health Plan of Northern Indiana, Inc. and PHP Insurance Company of Indiana, Inc.

1700 Magnavox Way, Suite 201
Fort Wayne, Indiana 46804
(PHP)

Welcome to PHP!

We partnered with your employer (who we reference as "Group" within this Certificate) to provide you with certain health insurance benefits. It is important that you read this Certificate carefully. It is a legal document explaining your Coverage. It explains your rights and obligations as a Member of PHP. It also describes the Health Services available under the Contract, how to get such services, the costs that you will need to pay and the benefits of seeking services from the Doctors, Providers and Hospitals that participate in our network. We call them "Par Providers" or "Participating Providers" in this Certificate.

The Coverage you have is based on the Contract between us and the Group and the benefit plan the Group selected. It is your responsibility to know the contents of this Certificate. Please refer to it before you seek Health Services, especially when you seek services from a non-Par Provider.

We know that health insurance is a complicated topic and that you may still have questions. Our customer service department is happy to answer any question or concern you may have about your Coverage or the procedures you must follow. You can reach us at the number on the back of your identification card. Our website (www.phpni.com) is an additional tool available to you.

NOTICE: 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. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Foreword

Introduction

We certify that you will be Covered as provided by the terms of the Contract as may be amended from time to time. The Contract and all Amendments are referred to as the Contract.

Possession of this Certificate does not necessarily mean that you are Covered. You are Covered only if you meet the requirements set out in the Contract.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Contract. This Certificate describes the provisions of the Contract but is not the entire Contract.

In the event of any conflict between the Contract and this Certificate, the Contract shall govern. You may examine the Contract at the office of the Group during its regular business hours.

This Certificate replaces and supersedes any Certificate which we may have previously issued to you. We may amend this Certificate from time to time and will provide you with a new Certificate or an Amendment to the Certificate. You should keep this Certificate and all Amendments to it.

How to Use This Certificate

This Certificate, including any Amendments, must be read in its entirety for a clear meaning. Many of its provisions are interrelated. You may get a false impression if you read just one or two provisions.

Many words used in this Certificate have special meanings. These words will appear capitalized and are defined. Refer to these definitions for a clear understanding of this Certificate.

The Contract may be amended from time to time. When that happens, we will send you a new Certificate or Amendment pages for this Certificate. Keep this Certificate in a safe place for your future reference.

Obtaining Health Services through PHP

The Contract provides you with Point of Service Coverage. Point-of-Service Coverage allows you to choose between receiving Health Services at In-Network (provided by PHP's Health Insuring Corporation) or Out-of-Network Benefit levels of Coverage (provided by PHP Insurance Company of Indiana, Inc., or PHPIC). If you wish to receive Coverage at the In-Network Benefit level, you must use Par Providers. The only exceptions are Emergency Health Services and approved Referral Health Services. Living outside the Service Area is not an exception.

If you otherwise obtain Health Services from non-Par Providers, you will receive Coverage at the Out-of-Network Benefit level, if it is available for a particular Health Service. Refer to the Schedule of Benefits for specific benefit information.

When you use non-Par Providers, you usually pay a greater share of the cost of the Health Services. In addition to Copays/Coinsurance and Deductibles, if applicable, you are responsible for all charges that exceed the Reasonable and Customary Charges for the Health Services received from a non-Par Provider, except for Emergency and approved Referral Health Services. A non-Par Provider may send you a bill seeking to collect such excess charges directly from you, which can be expensive.

If you wish to receive In-Network Benefits, you are responsible for verifying the participation status of a Provider before receiving Health Services. If you fail to check a Provider's participation status as required, and as a result, use a non-Par Provider, the Health Services will be covered as Out-of-Network Benefits (administered by PHPIC), if they are otherwise Covered by the Contract.

The participation status of a Provider may change from time to time. Therefore, it is important that you check

the status each time before receiving Health Services. We will notify our membership when a Par Provider terminates, including any Par Provider seen in the previous year.

You can verify a Provider's participation status by contacting us. We can give you the information you need in order to locate a Par Provider.

Except for Emergency Health Services, if you wish to receive In-Network Benefits for non-Par Provider's services, you are responsible for obtaining a written Referral before receiving such services. **A Par Doctor arranging or suggesting that you use a non-Par Provider is not a Referral.** Rather, a Referral to a non-Par Provider must be initiated in writing by a Par Doctor and approved in writing by us prior to the time of the service. ***Your failure to obtain the required Referral will result in the Health Services being Covered as Out-of-Network Benefits, if they are otherwise Covered by the Contract. Before seeing a provider based on the advice of another provider, please contact us. We can help you determine whether that provider is a Par Provider.***

Coverage for some Health Services under In-Network Benefits is subject to our prior written approval. Par Providers are responsible for obtaining our Prior Authorization for such services on your behalf. Coverage for some Health Services under Out-of-Network Benefits is also subject to our prior written approval. You, not the non-Par Provider, are responsible for obtaining our Prior Authorization for these services.

Par Providers will also submit claims to us on your behalf.

You are responsible for submitting claims to us for Health Services rendered by non-Par Providers. You must give us all of the information we need to process such claims. If you do not provide this information, you or the Provider may not be paid.

I.D. Card

Information on your I.D. card is needed for the Par Provider to bill us. *You must show your I.D. card every time you request Health Services.* If you do not show the card, Par Providers have no way of knowing that you are a Member.

When failure to show an I.D. card results in non-compliance with required procedures, we may deny Coverage.

Administrative and Fiduciary Responsibilities

PHP has sole and exclusive discretion to determine claims for benefits Covered under the Contract, including:

A. making the initial claims decisions;
B. resolving Appeals of those decisions pursuant to our Grievance procedures; and
C. communicating those decisions to the affected Members.

We may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Contract. To the extent the foregoing functions include fiduciary responsibilities under ERISA, if ERISA governs This Plan, PHP shall be the named fiduciary with respect to those functions.

We reserve the right, in our sole discretion, to:

A. change, modify, withdraw, or add benefits; and
B. to terminate the Contract, subject to its termination provisions.

Prior approval by Members of such benefit changes is not required. However, upon timely notification from the Group, we shall provide Members with notification of such benefit changes before they shall take effect.

The fact that we may have interpreted a provision of the Contract in a way that provides benefits shall not prevent us from later interpreting the same provision in a way that does not provide benefits, subject to compliance with ERISA and other applicable law. This paragraph applies only where the interpretation of this policy is governed

by ERISA, 29 U.S.C. 1001 *et seq*.

If the Contract is provided under an employee welfare benefit plan within the meaning of Section 3(1) of ERISA:

A. PHP and the Group acknowledge that the Group shall be the "Plan Administrator" of its group health plan within the meaning of ERISA, Section 3(16);
B. the Group shall have the responsibility to:
    1) communicate the terms and options of its group health plan to Members;
    2) furnish to Members summary plan descriptions, summary annual reports and such other disclosures as may be required by ERISA;
    3) submit required reports to the Internal Revenue Service and the U.S. Department of Labor; and
    4) comply with ERISA and other applicable law, as amended from time to time.

The Group is the named fiduciary with respect to the above functions to the extent they include fiduciary responsibilities under ERISA. Although PHP shall provide a Certificate, the Group understands that the Certificate is intended to comply with Ohio state law requirements, and is not intended to satisfy all of the plan document and/or summary plan description requirements of ERISA, to the extent it applies, which is the responsibility of the Group.

The Patient Protection and Affordable Care Act ("ACA") requires employers and health insurers to timely distribute a "Summary of Benefits and Coverage" or "SBC" to participants and beneficiaries. If the SBC rules apply to this Contract, PHP will provide the Group with SBCs for it to timely and properly distribute. The Group agrees that it is solely responsible for the distribution of SBCs to its Members, Subscribers, Enrolled Dependents, Eligible Persons, including individuals covered under COBRA, or others required by the ACA or other applicable law or regulation to receive SBCs. These individuals are the "Required Parties."

When there is a material modification of the Contract, PHP will provide the Group with an updated SBC unless:

A. the material modification does not affect the content of an SBC; or
B. the material modification is already reflected in the most recent SBC.

The Group will properly distribute the updated SBC to the Required Parties at least sixty (60) days before a material change can take place (unless it occurs in connection with the renewal of the Contract).

We may, in certain circumstances, Cover Health Services that would not otherwise be Covered. This is at our sole discretion and shall be done for purposes of overall cost savings or efficiency. The fact that we do so in any one case shall not in any way be deemed to require us to do so in similar cases.

We may, in our sole discretion, arrange for other parties to provide administrative services in regard to the Contract such as claims processing and utilization review services. You must cooperate with those parties in the performance of their duties. These service providers and the nature of the services provided may change from time to time. This is at our sole discretion. Prior notice to or approval by Members is not required.

We are a member of the guaranty fund pursuant to ORC 3956.01 and you are protected by the Ohio Life and Health Insurance Guaranty Association in the event of PHP's insolvency.

The Contract is filed with the Ohio Department of Insurance. Therefore, you have certain rights under state law. Refer to the Grievances section of the Contract for more information about these rights. You may also have certain rights under ERISA, if applicable.

Statement of ERISA Rights

This section applies to those Plans governed by ERISA. If the Contract was purchased by the Group to provide benefits under a welfare plan governed by ERISA, you are entitled to certain rights and protections under ERISA as explained below. Please remember that the Group is the Plan Administrator (unless it has delegated another person). All questions about whether This Plan is governed by ERISA should be directed to the Group.

Foreword

As a plan participant, ERISA provides that you are entitled to:

Receive Information about your Plan and Benefits

A. Examine, without charge, at the Plan Administrator's office and other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and, if applicable, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

B. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

C. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. There will be no charge for the report.

Continue Group Health Plan Coverage

A. If the Group is required to provide COBRA continuation coverage, continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review your summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

B. You may be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. The ACA prohibits health plans and policies from excluding claims solely due to a pre-existing condition.

Prudent Actions by Plan Fiduciaries

A. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce your Rights

A. If your claim for benefits under the benefit plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Please refer to the Grievances section.

B. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor. Or, you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

C. Group health plans and health insurance issuers, generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Assistance with your Questions

A. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
B. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 Member for certain services relating to a mastectomy.

If a Member 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:

A. all stages of reconstruction of the breast on which the mastectomy was performed;
B. surgery and reconstruction of the other breast to produce a symmetrical appearance;
C. prosthesis; and
D. treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage:

A. will be provided in a manner determined in consultation with the patient and the attending physician;
B. is subject to the Copays, Coinsurance and any Deductibles that are applicable to similar benefits under the Contract; and
C. will be provided regardless of whether the person was Covered under the Contract at the time of the mastectomy.

Statement of HIPAA Rights

This provision permits PHP to receive Protected Health Information in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

A. The Following Definitions Apply For Purposes Of This Provision:

1) "Health Maintenance Organization" is defined as it is in 45 Code of Federal Regulations (C.F.R.) 160.103, or any successor thereto.
2) "Health Insurance Issuer" is defined as it is in 45 C.F.R. 160.103, or any successor thereof.
3) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
4) "Protected Health Information" is defined as it is in 45 C.F.R. 164.501, or any successor thereto.

B. Plan Administrator's Certification Of Compliance

Prior to receiving any Protected Health Information, the Plan Administrator will certify that this provision has been incorporated into the Plan documents and that the Plan Administrator agrees to abide by the provisions herein. Neither the Plan, a Health Care Maintenance Organization, nor a Health Insurance

Issuer will disclose Protected Health Information to the Plan Administrator until the Plan Administrator has provided the certification, as required by HIPAA.

C. Permitted Uses And Disclosures

PHP, and if Section B is satisfied, the Plan Administrator, may use or disclose Protected Health Information to carry out Plan administration functions consistent with the requirements of HIPAA. Any disclosure to and use by PHP of Protected Health Information will be subject to and consistent with the provisions herein. PHP may use and disclose Protected Health Information to the extent necessary to comply with its obligations under HIPAA.

D. Responsibilities And Undertakings

1) PHP will not use or further disclose Protected Health Information, except as permitted or required by the Plan documents, as amended, or as required by law.
2) PHP will ensure that any agent, including any subcontractor to whom it provides Protected Health Information, agree to the same conditions and restrictions that apply to PHP.
3) PHP will not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Administrator or PHP.
4) PHP will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses and disclosures allowed under this provision promptly upon learning of the inconsistent use or disclosure.
5) PHP will make Protected Health Information available to the individual who is the subject of the information in accordance with 45 C.F.R. 164.524.
6) PHP will make an individual's Protected Health Information available for amendment, and will incorporate any amendments to the individual's Protected Health Information, in accordance with 45 C.F.R. 164.526.
7) PHP will keep track of disclosures it may make of Protected Health Information so that it can make available the information required for the group health plan to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528.
8) PHP will make its internal practices, books, and records, relating to its use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 C.F.R. Parts 160-64.
9) If feasible, PHP will return or destroy all Protected Health Information, in any form, received from the Plan, and PHP will not retain copies of the information after the information is no longer needed for the purpose for which the disclosure was made. If returning or destroying the information is not feasible, PHP will limit the use or disclosure of the information to those purposes that make the return or destruction infeasible.
10) PHP further agrees that if it creates, receives, maintains, or transmits any electronic protected health information, other than enrollment/disenrollment information and summary health information, it will comply with the HIPAA security regulations on behalf of the covered entity, and it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and it will ensure that any agents, including subcontractors, to whom it provides such electronic protected health information, agree to implement reasonable and appropriate security measures to protect the information. PHP will report to the Plan any security incident of which it becomes aware.
11) PHP will report any reportable breach to the affected individual, HHS and, if applicable, the media.
12) PHP will not use genetic information for underwriting.
13) PHP will not use Protected Health Information for marketing or fundraising, nor will it sell Protected Health Information.

E. Adequate Separation Between The Plan Sponsor And The Group Health Plan

As the covered entity, PHP, on behalf of the Plan does not provide Protected Health Information to the Plan Administrator or its agents. PHP, on behalf of the Plan may disclose Protected Health Information

to business associates. PHP will comply with sections 2) through 5) below.

1) The Plan Administrator shall insure that the adequate separation between the group health plan and the Plan Administrator is established.
2) All Employees, classes of Employees, or other workforce members as designated by the terms of the plan document, who have access to Protected Health Information, have been trained to appropriately handle Protected Health Information in accordance with the HIPAA privacy rules.
3) The Employees, classes of Employees or other workforce members identified in the plan document will have access to Protected Health Information only to perform the Plan's administration functions that the Plan Sponsor provides for the Plan.
4) The Employees, classes of Employees or other workforce members identified in the plan document will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Administrator for any use or disclosure of Protected Health Information that violates the provisions herein. The Plan Administrator will promptly report any violation to the Plan, as required by this provision. The Plan Administrator will also cooperate with the Plan to correct the violation, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the violation, and to mitigate any deleterious effect of the violation on the individual whose privacy rights may have been compromised by the violation.
5) The Plan Administrator will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

No Surprises Act

If you receive care from an out-of-network Provider or facility, your health plan may not Cover the entire cost. As a result, you may be left with higher costs than if you received care from an in-network Provider or facility. In the past, in addition to any out-of-network cost sharing you may owe, the out-of-network Provider or facility could bill you for the part of the bill that your health plan did not pay, resulting in a balance bill. An unexpected balance bill from an out-of-network Provider or facility is also called a surprise medical bill.

Starting in January 2022, new rules went into effect to protect you from surprise medical bills. These rules are sometimes called the "No Surprises" rules. These rules:

- Ban surprise medical bills for Emergency services, even if you get them out-of-network and without approval beforehand (Prior Authorization).
- Ban out-of-network cost-sharing (like out-of-network Coinsurance or Copayment) for all Emergency and some non-Emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for supplemental care (like anesthesiology or radiology) by out-of-network Providers who work at an in-network facility.
- Require that health care Providers and facilities give you an easy-to-understand notice explaining that getting care out-of-network could be more expensive and options to avoid balance bills. You're not required to sign this notice or get care out-of-network.

Also starting in January 2022, if you think your health plan's decision to not pay part or all of a claim violates the new surprise billing protections, you can Appeal that decision. You can use the external review process described in the plan document and denial notices to request the external review of your plan's decision to determine if your claim is subject to the No Surprises Act. If a claim is subject to the No Surprises Act, the Provider and PHP will follow the federal regulations to resolve any differences over the payment amount. This policy will be administered in accordance with the No Surprises Act and applicable regulations and, to the extent any provision of the Policy conflicts, the law will govern.

If you have a question about these new rules or believe the rules are not being followed, contact the "No Surprises" Health Desk at 1-800-985-3059 or submit a complaint online at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Contact PHP

Your satisfaction as a Member is very important to us. Please call us if you have a question or concern about your Coverage or procedures you must follow. You can reach our Customer Service Department during normal business hours as follows: (260) 432-6690, Extension 11; 1-800-982-6257, Extension 11; or custsvc@phpni.com (e-mail).

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RESERVED FOR
SCHEDULE OF BENEFITS

Benefits and Services

Refer to the Schedule of Benefits for specific benefit information.

Medical Services in a Doctor's Office

We will Cover Health Services provided in a Doctor's office. A Doctor must order and provide or direct such services. A Deductible or an additional Copay or Coinsurance may apply for certain diagnostic, lab or x-ray services as set forth in the Contract.

Diagnostic Services

When specific symptoms exist, we will Cover routine diagnostic services performed to diagnose a medical condition, as ordered by a Doctor. A Doctor must perform such services, which include:

A. routine radiology services, such as but not limited to: chest x-ray or MRI; or
B. routine lab services, such as but not limited to: pregnancy test; blood test; or urine test.

Preventive Care

PHP covers a comprehensive range of preventive care services, including the preventive services required by the ACA. To be considered "preventive care," you must not have symptoms or a history of the health problem, which is the subject of the office or outpatient visit. There are no cost-sharing (Copay, Coinsurance or Deductible) requirements associated with preventive care if you visit a Participating Provider. If you visit a non-Par Provider for preventive care services and if this Contract covers out-of-network services, then you shall pay the normal cost-sharing as shown on your Schedule of Benefits. If this Contract does not cover out-of-network services, then preventive care services received from a non-Par Provider will not be Covered.

If you have current symptoms or a history of a health problem, which is the subject of the office or outpatient visit, you must pay the cost-sharing amount shown on your Schedule of Benefits. Similarly, if the primary purpose of the office or outpatient visit is for reasons other than preventive care, you must pay the cost sharing amount shown on your Schedule of Benefits even if you received Covered preventive services during the visit. Services received outside of an office or outpatient setting are not preventive care services.

Covered preventive care services include:

A. services with an "A" or "B" rating as described in the United States Preventive Services Task Force ("USPSTF") recommendations;
B. preventive care services for smoking cessation and tobacco cessation for adult Members, as described in USPSTF recommendations;
C. immunizations as described in the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention;
D. services described in certain guidelines for infants, children, adolescents and women supported by the Health Resource and Services Administration ("HRSA"); and
    1) Child Health Supervision benefits will be provided at no cost sharing in accordance with the Federal preventive care mandate; the remaining benefits may require cost sharing.
E. services described in the Women's Preventive Services Guidelines of the HRSA, including contraception coverage described below which is subject to change if the HRSA guidelines change;
    1) PHP will cover at least one form of each FDA approved contraceptive method with no cost sharing;
    2) Coverage includes clinical services such as patient education and counseling needed for the provision of the contraceptive method;
    3) PHP will have an easy exception process. This process will specify that if an attending Provider recommends a particular contraceptive based on Medical Necessity, PHP will defer to the determination of the Provider and provide that contraceptive with no cost sharing.

PHP will Cover, in addition to the Federal requirements above, the following services as preventive care to the extent required by Ohio law:

A. routine mammography screenings, of which the total benefit paid (including any cost sharing) will not

exceed 130% of the Medicare reimbursement amount;

B. supplemental breast cancer screenings, of which the total benefit paid (including any cost sharing) will not exceed 130% of the Medicare reimbursement amount; digital breast tomosynthesis (3D imaging); cytologic screenings; and one screening mammogram every year including supplemental screenings for adult woman who;
   1) previous screening mammogram demonstrated presence of dense breast; increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition or other reasons as determined by the Member's health care provider.

C. newborn infant screenings including, but not limited to, Adrenoleukodystrophy (ALD).

To the extent treatments or services are not determined to be preventive care, the treatments or services may be Covered under other terms of this Contract. Please note that PHP shall administer these preventive care benefits consistently with Federal and/or State regulations. Certain conditions and/or standards must be met for PHP to consider such services "preventive" with no applicable cost-sharing requirements by you. Services that exceed the applicable preventive care thresholds shall be subject to normal cost-sharing. For example, if you are eligible to receive an annual preventive care recommended colorectal cancer screening, but receive two such screenings in a Calendar Year, the first screening will be reimbursed as preventive care with no cost-sharing requirements required by you. You must pay the normal cost-sharing as shown on your Schedule of Benefits for the second screening.

If you have questions about benefits that are Covered under this Preventive Care section, you may contact PHP's Customer Service Department: (260) 432-6690, Extension 11; (800) 982-6257, Extension 11; (260) 432-0493 (fax); custsvc@phpni.com (email); or www.phpni.com. You can also view the Federal Government's websites, including: www.uspreventiveservicestaskforce.org, www.cdc.gov/vaccines/acip/index.html or www.hrsa.gov.

Outpatient Surgical, Medical and Professional Services

We will Cover outpatient Health Services provided in a Hospital; Alternate Facility; lab; or x-ray facility. A Doctor must order and provide or direct such services.

Outpatient services include:

A. treatment of Injury or Sickness, such as but not limited to: operating room services; diagnostic tests; therapeutic services; Health Services to treat diabetes; Reconstructive Surgery; Health Services to treat complications of Substance Use Disorder; medications and dressings; and non-disposable medical supplies.
B. medical care, such as but not limited to: well-baby care; physical exams; colonoscopies; voluntary family planning; and Routine Immunizations.
C. radiation therapy services.

Inpatient Surgical, Medical and Professional Services

We will Cover inpatient Health Services for Confinement in a Hospital or other facility we approve. Certain Health Services received during Confinement are subject to separate benefit restrictions and/or Copays/Coinsurance such as but not limited to rehab services.

Inpatient Services include:

A. treatment of an Injury or Sickness, such as but not limited to: diagnostic tests; therapeutic services; Health Services to treat diabetes; Reconstructive Surgery; Health Services to treat complications of Substance Use Disorder; medications; and dressings.
B. Semi-private Room or, if supported by Medical Necessity, an intensive specialty care unit room or a private room. No more than one room rate per day is Covered.
C. related services and supplies, such as but not limited to operating room charges.

Emergency Health Services

We will Cover Emergency Health Services:

A. provided by a Par or non-Par Provider in a Hospital Emergency room as In-Network Benefits (see additional detail below). The Emergency room Copay is waived if you are admitted on an inpatient basis for the same condition within twenty-four (24) hours of treatment.
B. to treat an Injury or Sickness provided in an Urgent Care Center.

Our policy providing Coverage of Emergency Health Services shall Cover the following:

A. Emergency services provided to a Member at a Participating Hospital's Emergency department if the Member presents self with an Emergency medical condition;
B. Emergency services provided to a Member at a non-Participating Hospital's Emergency department if the Member presents self with an Emergency medical condition and one of the following circumstances applies:
    1) Due to circumstances beyond the Member's control, the Member was unable to utilize a Participating Hospital's Emergency department without serious threat to life or health.
    2) A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a Participating Hospital's Emergency department could result in serious adverse health consequences.
    3) A person authorized by the health insuring corporation refers the Member to an Emergency department and does not specify a Participating Hospital's Emergency department.
    4) An Ambulance takes the Member to a non-Participating Hospital other than at the direction of the Member.
    5) The Member is unconscious.
    6) A natural disaster precluded the use of a Participating Emergency department.
    7) The status of a Hospital changed from Participating to non-Participating with respect to Emergency services during a Contract Year and no good faith effort was made by the health insuring corporation to inform Members of this change.

Our policy providing Coverage of basic health care services Covers Emergency services for Members with Emergency medical conditions without regard to the day or time the Emergency services are rendered or to whether the Member, the Hospital's Emergency department where the services are rendered, or an Emergency Physician treating the Member, obtained Prior Authorization for the Emergency services.

The Contract does not Cover non-Emergency Health Services received in a Hospital Emergency room. Certain Health Services may be subject to benefit restrictions described elsewhere in the Contract.

Urgent Care Services

Urgent Care is the treatment of an unexpected Sickness or Injury that is not life or limb threatening, but requires prompt medical attention. Urgent Care services are not the same as Emergency Health Services. They do not call for the use of a Hospital Emergency room. Urgent Care services received in a Hospital Emergency room are not Covered.

Ambulance Service

The Contract Covers Ambulance services provided by a licensed Ambulance service for:

A. Emergency Ambulance transportation to the nearest Hospital where Emergency Health Services can be provided for the emergent condition.
B. non-Emergency Ambulance transportation if such service is:
    1) recommended by a Doctor;
    2) Medically Necessary; and
    3) approved in advance by PHP.

Home Health Agency Services

Such services must be ordered by a Doctor and provided by a licensed registered nurse. The Contract does not Cover Custodial Care. Covered services are limited to those which would be performed if you were Confined to the home for medical reasons and physically unable to obtain needed medical services on an outpatient basis.

Hospice Care and Services

We will Cover inpatient and outpatient Hospice Care and Services related to or resulting from a Member's terminal Sickness when:

A. a Doctor recommends such services;
B. a Doctor certifies the Member to be terminally ill with six (6) months or less to live;
C. you receive such services in a Hospice Facility or in the home by a Hospice Care Agency; and
D. a Provider orders, arranges or provides the services.

There is no Coverage under this Contract for:

A. funeral arrangements;
B. bereavement, pastoral or legal counseling;
C. homemaker or Care Taker Services; or
D. Respite Care.

Health Services that would otherwise require Confinement in:

A. a Hospital;
B. an Approved Inpatient Transitional Care Unit; or
C. a Home Health Agency;

are subject to separate benefit restrictions and/or Copays/Coinsurance. These are described elsewhere in the Contract, for example, the number of Home Health Agency days.

Inpatient Transitional Care Unit Services

We will Cover Confinement in an Approved Inpatient Transitional Care Unit when ordered by a Doctor. Coverage is:

A. limited to care and treatment of an Injury or Sickness in lieu of an acute inpatient stay; or
B. provided for a Semi-private Room, related services and other supplies.

Certain Health Services rendered during Confinement are subject to separate benefit restrictions and/or Copay/Coinsurance described elsewhere in the Contract such as but not limited to rehab services. This Contract does not Cover Custodial Care.

Durable Medical Equipment (DME), Prosthetics, Orthotic Appliances and Ostomy Supplies

We will Cover:

A. DME, prosthetics, Orthotic Appliances ordered by and provided by a Provider for use outside a Hospital or Approved Inpatient Transitional Care Unit;
B. Ostomy Supplies obtained from a Provider;
C. a prosthetic arm, hand, leg or foot (and the Orthotic Device that is part of a prosthesis), including the repair or replacement of a prosthesis, ordered by and provided by a Provider when your physician determines it to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job-related activities; and

This Contract limits Coverage to:

A. an initial purchase or rental of an item based on Medical Necessity or change in medical condition, as we determine, and appropriate for your Basic Health Needs;
B. replacement of a prosthetic device while you are a Member only if Medically Necessary;
C. repair or replacement, at our discretion, of an item, rather than Cover the purchase of a new item. The cost to repair an item is limited to the replacement cost of such item; and

D. supplies associated with the initial purchase, repair or replacement of an item.

This Contract does not Cover:

A. items/features which merely contribute to your convenience, such as but not limited to: electric wheelchairs; motor vehicles; scooters; lifts for wheelchairs; and the like;
B. thermal or cooling devices, such as but not limited to, Game Ready Accelerated Recovery System, Cryo/Cuff by Aircast, and AutoChill Accessory Kit by Aircast, except in accordance with our guidelines;
C. pneumatic compression devices unless otherwise authorized and in accordance with PHP's medical policies;
D. batteries needed to operate any item;
E. items which are ordered and/or fitted that you did not take possession of while a Covered Member under the Contract;
F. items ordered and/or fitted before your effective date of Coverage; and
G. the repair of items damaged due to negligence, abuse, excessive wear and tear or misuse.

PHP imposes restrictions on certain Durable Medical Equipment vendors unless approved in advance by PHP through its Prior Authorization process.

- Durable Medical Equipment billed by or through Integrated Orthopedics is not Covered.
- Durable Medical Equipment Coverage cannot be greater than three times the industry average, as determined by PHP in its sole discretion.

If a Member pays an online retailer for medically prescribed Covered Durable Medical Equipment (like Amazon), the Member may submit evidence of such payment to PHP within ninety (90) days from the date of service, together with the claim information, including, but not limited to, Member identification, date of service, metric quantity dispensed, days' supply, amount paid, and the prescribing Physician. PHP will evaluate such claim and determine, in its sole discretion, if the claim is otherwise reimbursable under the terms of the Policy, including all limitations, exclusions, and cost sharing provisions; provided, however, under no circumstance will PHP pay more than the amount that would have been payable if provided under our Participating Provider contract. Shipping and handling charges are excluded from reimbursement.

Therapy Services (Rehabilitation Services/Habilitation Services)

We will Cover certain therapy services, as applicable, for Rehabilitation Services or Habilitation Services that:

A. a Doctor orders;
B. a Provider or Facility provides;
C. will result, in the judgment of a Par Doctor and PHP, in a practical improvement of your condition within a reasonable period of time after the start of such services; and
D. are Medically Necessary.

The Contract limits Coverage to the following:

Physical Medicine Therapy Services

A. **Physical therapy** given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. It includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. The Contract does not Cover the following: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
B. **Speech therapy** for the correction of a speech impairment.

C. **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g., hobbies, arts and crafts). Non-Covered Health Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

D. **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar. Chiropractic therapy focuses on the joints of the spine and the nervous system. Osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations, whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit, will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. The Contract does not Cover Manipulation Therapy services rendered in the home as part of Home Care Services. Experimental, Investigational and Unproven Services, such as but not limited to: VAXD; Lordex; ART; DRS; and posture pump are not Covered.

Other Therapy Services

A. **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered. Such cardiac rehabilitation must meet our guidelines to be Covered.

B. **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

The Contract does not Cover therapy services, either as Rehabilitation Services or Habilitation Services, when treating chronic conditions for which there is no reasonable expectation of significant improvement.

Transplant Procedure Services

We will Cover select inpatient and outpatient services associated with certain organ transplants, including stem cell transplants. Services must be ordered, planned, provided or arranged by a Doctor and performed at a Designated Transplant Center of Excellence (Center of Excellence). Transplant services performed at a non-Center of Excellence are not Covered. Corneal transplants do not need to be performed at a Center of Excellence, but must meet all other guidelines. Such Centers of Excellence shall be defined by us. Transplant coverage may be deferred to and governed by a contracted third-party transplant manager, specializing in such transplants.

Coverage is provided for the procurement and transplant of organs. Transplant procedure services must:

A. be Medically Necessary;
B. be determined not to be Experimental, Investigational, or Unproven by PHP, or our contracted third-party transplant manager, at the time we make a Coverage determination;
C. not involve artificial, mechanical or animal organs; and
D. approved by PHP or its contracted third-party transplant manager, in advance.

We provide Coverage for Hospital and medical expenses related to an unrelated donor search (donor organ,

donor tissue or prospective donor) limited to a $30,000 benefit limit per transplant procedure, but only if our guidelines are met.

Hospital and medical expenses for a donor or donor organ are Covered except:

A. no Coverage is provided for the purchase of an organ or donor tissue if the organ or donor tissue is sold rather than donated; and
B. no Coverage is provided for donor expenses when the recipient is not a Member.

Unless excluded below, Coverage will be provided for expenses for travel to and lodging near a Center of Excellence for an eligible transplant candidate and companion under the following limitations:

A. The Center of Excellence is more than 50 miles from the Member's home address;
B. Travel will be Covered for the Member and one companion, unless the Member is 18 years old or younger, in which case two companions' travel expenses will be covered;
C. Travel expenses will include: automobile mileage at the current IRS rate, flights (economy or coach seats only) and hotel rooms;
D. All travel expenses, taken together, for any one transplant procedure may not exceed $10,000; and
E. Only those travel expenses associated with the actual transplant procedure will be Covered, but will not be reimbursed until after the transplant procedure occurs.

Non-Covered services for transportation and lodging include, but are not limited to the following:

A. Meals;
B. Child care;
C. Mileage within the medical transplant facility city;
D. Rental cars, buses, taxis, or shuttle services, unless authorized in advance by us;
E. Frequent flyer miles;
F. Coupons, vouchers, or any travel upgrades;
G. Prepayments or deposits;
H. Services for a condition that is not directly related, or a direct result, of the transplant;
I. Telephone calls;
J. Laundry;
K. Postage;
L. Entertainment, including in-room video and/or movie entertainment;
M. Travel expenses for donor companion/caregiver; and
N. Return visits for the donor for a treatment of a condition found during the evaluation.

Services are Covered at the specific benefit level as outlined throughout this Contract.

Gene Therapy

We will Cover select inpatient and outpatient services associated with certain gene therapies including but not limited to CAR-T or Zolgensma. Services for gene therapy must be ordered, planned, provided or arranged by a Doctor and performed at a Designated Center of Excellence (Center of Excellence). Service performed at a non-Center of Excellence may not be Covered. Such Centers of Excellence shall be defined by us.

Coverage for gene therapy services must:

A. be Medically Necessary;
B. be determined not to be Experimental, Investigational, or Unproven by PHP, or our contracted third-party transplant manager, at the time we make a Coverage determination;
C. approved by PHP or its contracted third-party specialty therapy manager, in advance.

Services are Covered at the specific benefit level as outlined throughout this Contract.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder Services

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. Covered services must be provided according to our guidelines, require Prior Authorization and are limited to Medically Necessary services, including certain surgeries, injections, manipulations and appliances. Covered Services do not include Cosmetic Procedures or services, fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures). Braces for teeth, experimental services and non-Medically Necessary services are not Covered. Services are limited to one treatment per side of the head, per lifetime.

Maternity Services

We will Cover Maternity Services for normal and complicated pregnancies when ordered by, provided by or under the direction of a Doctor.

We provide benefits for an inpatient stay at a Hospital of at least:

A. forty-eight (48) hours for the mother and newborn following a normal vaginal delivery; or
B. ninety-six (96) hours for the mother and newborn following a cesarean birth.

An authorization is required for a Hospital stay in excess of forty-eight (48) hours or ninety-six (96) hours.

A shorter stay is allowed if the mother and attending Doctor together decide that further inpatient stay is not necessary for the mother or newborn. When a shorter stay is elected, PHP will provide Coverage for seventy-two (72) hours of follow-up care. This visit must:

A. be performed at the mother's choice, at the mother's residence or at the Provider's facility or office.

Autism Spectrum Disorder (ASD) Services

Covered services include, but are not limited to, benefits for children with a medical diagnosis of Autism Spectrum Disorder for:

A. Outpatient physical rehabilitation services including:
    1) Speech and language therapy and/or occupational therapy, performed by a licensed therapist, limited to the visits shown in the Schedule of Benefits; and
    2) Clinical therapeutic intervention defined as therapies supported by empirical (factual) evidence, which include, but are not limited to, applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the state of Ohio to perform the services in accordance with a treatment plan, limited to twenty (20) hours per week.
    3) Mental/Behavioral Health outpatient services performed by a licensed psychologist, psychiatrist, or physician to provide consultation, assessment, development and oversight of treatment.

Coverage provided under this section is contingent upon both of the following:

A. The Member receiving Precertification for the services;
B. The services being prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism.

Except for inpatient services, if a Member is receiving treatment for an Autism Spectrum Disorder, we may review the treatment plan annually, unless we and the Member's treating physician or psychologist agree that a more frequent review is necessary. Any agreement shall apply only to a particular Member being treated for an Autism Spectrum Disorder and shall not apply to all individuals being treated for Autism Spectrum Disorder by a physician or psychologist. We will Cover the cost of obtaining any review or treatment plan.

Diabetes Services

We will Cover Health Services and self-management training for diabetes that is:

A. Medically Necessary; and
B. ordered and provided by or under the direction of a Provider.

Cancer Chemotherapy Treatment

We will Cover cancer chemotherapy treatment when ordered by and provided by a Provider.

Orally Administered Cancer Medication

We will Cover all orally administered cancer medications on the same basis and at no greater cost sharing than imposed for IV or injected cancer medication.

Outpatient Prescription Drugs

We will Cover outpatient Prescription Drugs that are prescribed by a Prescriber and dispensed at a Par Pharmacy, Specialty Pharmacy or through a Par Mail Order Drug Provider as set forth in the Schedule of Benefits. Prescription Drugs must be Medically Necessary and, when required by us, Prior Authorized in advance. Refer to the Schedule of Benefits for specific benefit information.

Prescriptions filled at non-Par Pharmacies or through non-Par Mail Order Drug Providers are not Covered, except in the event of an Emergency as specified in the Contract. Under this exception, your Copays/Coinsurance, supply units, etc. are the same as the applicable Par requirements set forth in the Schedule of Benefits.

When Prior Authorization is required for Coverage of certain Prescription Drugs, it should be initiated by the Prescriber, Par Pharmacy or Specialty Pharmacy. If Prior Authorization is not received, the Member may submit a claim accompanied by supporting documents to PHP for Coverage consideration.

Member Responsibility

A. any applicable Copay/Coinsurance or Deductible or, if less than any Copay/Coinsurance or Deductible, the Provider's Reasonable and Customary Charge;
B. Additional Charge (if any);
C. 100% of the cost of a Prescription Drug when Step Therapy is not followed, unless you or your Doctor have requested, and PHP has granted, a Step Therapy exception (see the section "Step Therapy Protocol Exception");
D. 100% of the cost of drugs or supplies not Covered;
E. 100% of the cost of that portion of a Prescription Drug that exceeds the Contract's dispensing limits; and
F. 100% of the cost of Covered Prescription Drugs when you fail to show your I.D. card.

When the Outpatient Prescription Drugs benefit has an applicable Copay, we use a five-tier system that takes into consideration a number of factors, including the usage, cost and clinical effectiveness of Prescription Drugs. We recommend that you check the Schedule of Benefits, which will identify the applicable Deductible, Copay and/or Coinsurance whether or not the tier system applies to your benefit.

Tier 1 (preferred Generic Drugs) – this tier typically has the lowest Copays and/or the lowest Coinsurance. It includes some Generic Drugs and may include other low-cost drugs.

Tier 2 (non-preferred Generic Drugs) – this tier typically has Copays and/or Coinsurance that are higher than Tier 1, but lower than all other tiers. It includes some Generic Drugs and may include other low-cost drugs.

Tier 3 (preferred Brand Drugs) – this tier typically has Copays and/or Coinsurance higher than those in Tier 1 or Tier 2. This tier includes some Brand Name Drugs and other high-cost drugs, but may also include Generic

Drugs.

Tier 4 (non-preferred Brand Drugs) – this tier typically has Deductibles and then Copays and/or Coinsurance higher than all other tiers except for Tier 5. It includes some Brand Name Drugs and other high-cost drugs, but may also include Generic Drugs.

Tier 5 (Specialty Drugs) – this tier does not have Copays, but typically has the highest Coinsurance and includes Specialty Drugs, high-cost drugs and may also include generic drugs. Prescription Drugs in this tier are limited up to a thirty (30) day supply, except when a manufacturer's packaging further limits the supply.

Your share of the cost of Prescription Drugs may vary depending on the tier the Prescription Drug is in when your Prescription is filled. The higher the tier, the more you will typically have to pay for a Prescription Drug. Please refer to the Schedule of Benefits for applicable cost sharing. The use of Generic Drugs/Prescription Drugs/Specialty Drugs to describe the tiers is for educational purposes. Such use does not guarantee where we place drugs amongst the tiers. During the course of the Plan Year, we may change the placement of a particular Prescription Drug among the tiers. This change may occur without prior notice to you. Because of such potential tier-status changes, the amount you may have to pay for a particular Prescription Drug may be lower or higher than what you may have previously paid for a particular Prescription Drug. If you have questions about the tier status of a Prescription Drug, we encourage you to contact our Customer Service department or to check our website at www.phpni.com.

Generic Drugs are typically the most affordable drugs. Depending on the applicable tier, Generic Drugs offer you more affordability than do Brand Name Drugs. Please note that not all strengths and formulations of Generic Drugs have the same tier status. Prescription Drugs will be dispensed as ordered by your Prescriber. You may ask for (or the Prescriber may order) a Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between Brand Name Drug and the Generic Drug, plus the applicable Copay (see, Schedule of Benefits). Because Generic Drugs, by law, must meet the same regulatory standards for safety, strength and effectiveness, using Generic Drugs generally saves you money, yet provides the same quality.

You must present your I.D. card to the Par Pharmacy when filling a Prescription Drug. The Par Pharmacy will file your claim with us on your behalf. You may be charged cost-sharing at the point of purchase. If you do not present your I.D. card, you will have to pay 100% of the cost of Covered Prescription Drugs. Prescription benefits may be subject to additional cost-sharing as described in this Certificate.

Members are required under this Contract to pay the applicable cost sharing, which includes the Deductible, Copays or Coinsurance as shown on the Schedule of Benefits. The requirement to pay the applicable cost sharing (Deductible, Copays or Coinsurance) cannot be waived by a Provider, a Pharmacy or anyone else under any "fee forgiveness," "not out-of-pocket," "discount program," "coupon program" or similar arrangement. To the extent a Provider, Pharmacy or third party (other than family) waives, discounts, reduces, or indirectly pays the required cost sharing (Deductible, Copays, 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. Furthermore, the total amount accumulated toward any overall Deductible and/or maximum Out-of-Pocket amounts as shown on the Schedule of Benefits will be reduced by the amount of such waiver, discount, reduction or third-party payment. If Copay assistance is used by a Member, then PHP maintains the right to receive the Copay assistance amounts from Providers.

If a Prescription includes more than one Covered Prescription Drug, a separate Copay or Coinsurance will apply to each Prescription Drug.

If a Member pays a Participating Pharmacy for a medically prescribed Covered Prescription Drug using a pricing application (like GoodRX), the Member may submit evidence of such payment to PHP within ninety (90) days from the date of service, together with the claim information, including, but not limited to, Member identification, date of service, metric quantity dispensed, days' supply, amount paid, and the prescribing Physician. PHP will

evaluate such claim and determine, in its sole discretion, if the claim is otherwise reimbursable under the terms of the Policy, including all limitations, exclusions, and cost sharing provisions; provided, however, under no circumstance will PHP pay more than the amount that would have been payable if provided under our pharmacy benefit contract. Shipping and handling charges are excluded from reimbursement.

PHP will not require a cost share that is greater than the amount an individual would pay for the drug if it were purchased without Coverage. Additionally, off label use may be approved when the drug has been recognized as safe and effective for treatment of the health indication in one or more of the standard medical reference compendia adopted by the Department of Health and Human Services, or literature that meets certain criteria.

Step Therapy Protocol Exception

If you or your Doctor want to request an exception for a Prescription Drug not recommended according to the Step Therapy Protocol, you or your Doctor can contact us by calling Customer Service and we will provide you with a copy of the form for requesting a protocol exception.

Upon receipt of your Step Therapy Protocol Exception Request or Appeal of a denial of a protocol exception request, we will make a determination not more than:

A. in an urgent care situation, one (1) business day after receiving the request or Appeal; or
B. in a non-urgent care situation, three (3) business days after receiving the request or Appeal.

We will approve the protocol exception request in any of these situations:

A. your preceding Prescription Drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to you. Here, a preceding Prescription Drug is the prescription drug that must first be used and found to be inappropriate to treat your condition in order for PHP to Cover a subsequent treatment with a different prescription drug.
B. your preceding Prescription Drug is expected to be ineffective, based on both of the following:
   1) your known clinical characteristics; and
   2) the known characteristics of the preceding Prescription Drug, as found in sound clinical evidence.
C. you have previously received either (1) a preceding Prescription Drug or (2) another Prescription Drug that is in the same pharmacologic class or has the same mechanism of action as the preceding Prescription Drug, and that Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
D. based on clinical appropriateness, a preceding Prescription Drug is not in your best interest because your use of the preceding Prescription Drug is expected to:
   1) cause a significant barrier to your adherence to or compliance with your plan of care;
   2) worsen your comorbid condition; or
   3) decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

We may request a copy of relevant documentation from your medical record in support of the protocol exception.

We will notify you and your Doctor if a protocol exception is approved.

If we deny your protocol exception request or your Appeal of a denied protocol exception request, we will notify you and your Doctor of the denial and include a detailed, written explanation of the reason for the denial, and the clinical rationale that supports the denial.

As used in this section:

“Protocol exception” means our determination that, based on a review of a request for the determination and any supporting documentation: (1) a step therapy protocol is not medically appropriate for treatment of your particular condition; and (2) we will (A) not require your use of a preceding prescription drug under the step therapy protocol; and (B) provide immediate coverage for another prescription drug that is prescribed for you.

"Step therapy protocol" means a protocol that specifies, as a condition of coverage under This Plan, the order in which certain prescription drugs must be used to treat your condition.

"Urgent care situation" means an injury or condition that, if medical care or treatment is not provided earlier that the time frame generally considered by the medical profession to be reasonable for a non-urgent situation, could seriously jeopardize your life, health, ability to regain maximum function, or could subject you to severe pain that cannot be adequately managed, based on your Doctor's judgment.

Drug Formulary Changes and Requests

In the event that PHP would remove a Prescription Drug from our drug Formulary in the middle of the Calendar Year, PHP will send a written notice of the removal or change to each Member at least sixty (60) days before the change is effective. Members may request an extension of Coverage for the Prescription Drug. If a drug is not currently Covered in the drug Formulary, Members may request Coverage for the Prescription Drug.

If the Member request is supported by documentation from the Prescriber, PHP shall make a determination concerning the Member's request:

A. in an Urgent Care situation, not more than one (1) business day after receiving the request; or
B. in a non-urgent situation, not more than three (3) business days after receiving the request.

If the Member request is granted by PHP, we will notify the Member and the Prescriber of the authorization for Coverage of the Prescription Drug that was the subject of the request. This extension of Coverage will be through the end of the Calendar Year and is permitted only once and may not be repeated unless otherwise provided by PHP.

Nothing prohibits PHP from removing a Prescription Drug from our drug Formulary or denying Coverage if:

A. the federal Food and Drug Administration has issued a statement about the Prescription Drug that calls into question the clinical safety of the Prescription Drug;
B. the manufacturer of the Prescription Drug has notified the federal Food and Drug Administration of a manufacturing discontinuance or potential discontinuance of the Prescription Drug; or
C. the manufacturer of the Prescription Drug has removed the Prescription Drug from the market.

Behavioral Health and Mental Health and Substance Use Disorder

This benefit addresses the services and the supplies for the diagnosis and treatment of Behavioral Health and Mental Health and Substance Use Disorder that are classified in the ICD or DSM. The services and supplies set forth herein will be Covered the same as any other medical or surgical condition, subject to the terms and limitations set forth in the Contract. Refer to the Schedule of Benefits for specific benefit information.

We will Cover outpatient services for the diagnosis and treatment of Behavioral Health and Mental Health and Substance Use Disorder, including but not limited to: diagnostic, intensive outpatient, and partial hospitalization when ordered and provided by or under the direction of a Provider. We will Cover Confinement in a Par Hospital or other facility approved by PHP when ordered and provided by or under the direction of a Provider. Coverage includes a Semi-private Room and related Eligible Expenses. A private room is only Covered when supported by Medical Necessity and approved by PHP in advance.

The Mental Health Parity and Addiction Equity Act provides for equality in the insurance coverage, treatment limits and financial coverage, of behavioral health/substance abuse benefits and medical/surgical benefits. Generally, a plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on behavioral health and substance abuse benefits. Additionally, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on behavioral health and substance abuse benefits that are more restrictive than those applicable to other medical/surgical benefits.

Approved Clinical Trials

We will Cover services for routine patient care rendered as part of an approved clinical trial if such services are already Covered by the Contract and meet our guidelines, as detailed in ORC 3923.80 and federal requirements. The approved clinical trial must be a Phase I, II, III or IV research study and:

A. be conducted using a particular care method to prevent, diagnose or treat a cancer or other life-threatening disease or condition for which:
   1) there is no clearly superior, non-investigational alternative care method;
   2) available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any non-investigational alternative care method;
B. be conducted in a facility where personnel providing the care method to be followed in the research study have:
   1) received training in providing the care method;
   2) expertise in providing the type of care required for the research study; and
   3) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise;
C. be conducted to scientifically determine the best care method to prevent, diagnose, or treat the cancer or life-threatening disease or condition; and
D. be approved or funded by one of the following:
   1) A National Institutes of Health institute;
   2) A cooperative group of research facilities that has an established peer review program that is approved by a National Institutes of Health institute or center;
   3) The United States Food and Drug Administration;
   4) The United States Department of Veterans Affairs;
   5) The United States Department of Defense;
   6) The institutional review board of an institution located in Ohio that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103;
   7) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health Center.

"Routine care cost" means the cost of Medically Necessary services related to the care method that is under evaluation in an approved clinical trial. It does not include and we will not Cover the following:

A. The health care service, item, or investigational drug that is the subject of the clinical trial.
B. Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial.
C. Any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
D. An investigational drug or device that has not been approved for market by the United States Food and Drug Administration.
E. Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility where a clinical trial is conducted.
F. A service, item, or drug that is provided by a clinical trial sponsor free of charge for any patient.
G. A service, item or drug that is eligible for reimbursement from a source other than a covered individual's policy of accident and sickness insurance, including the sponsor of the clinical trial.

Members must meet all applicable plan requirements for participation. However, Coverage is not limited to a "qualified individual" as defined in federal law, and Members are not required to have a Referral from a Participating health professional or provide medical and scientific information establishing the appropriateness of participation. All applicable plan limitations for Coverage of out-of-network care will apply to routine patient care costs in approved clinical trials. All utilization management rules and coverage policies that apply to routine care for Members not in approved clinical trials will also apply to routine patient care for Members in approved

clinical trials.

Telehealth Services

Telehealth Services performed by Providers may be available under your Contract. To be Covered, the underlying Health Services must be Covered by the Contract.

PHP will not impose a cost-sharing requirement for Telehealth Services that exceeds the cost-sharing requirement for comparable in-person health care services. PHP will not impose a cost-sharing requirement for a communication when all of the following apply:

A. The communication was initiated by the health care professional.
B. The patient consented to receive a Telehealth Service from that Provider on any prior occasion.
C. The communication is conducted for the purposes of preventive health care services only.

Telehealth Services will not be denied solely because the services were not provided on a face-to-face basis.

Gender Dysphoria

We may cover transgender surgery procedures for a Member when all of the following criteria are met:

A. the Member has persistent, well-documented definitive diagnosis of gender dysphoria from a Doctor;
B. the Member has received continuous hormone therapy for twelve (12) months or more under the supervision of a Doctor, unless the Member has a medical contraindication;
C. the Member has lived as their reassigned gender full-time for twelve (12) months or more (which may be concurrent with Item B. above);
D. a written psychological assessment from at least two qualified behavioral health providers experienced in treating gender dysphoria documents all required criteria as per PHP's medical policies including capacity to make a fully informed decision and consent for treatment;
E. the Member's medical and mental health providers document that there are no contraindications to the planned surgery and agree with the plan, within three (3) months of PHP's approval;
F. Member is at least 18 years of age (age of majority); and
G. PHP provides written, prior approval of the transgender surgical procedure as Medically Necessary.

Notwithstanding the foregoing, we do not cover the reversal of any transgender surgery. In addition, we do not cover the procedures listed below performed for the purpose of transgender surgery because they are considered cosmetic for all Members (this list is not all-inclusive): body contouring procedures; vocal cord surgery for voice modification; voice training; hair removal, except as Medically Necessary: and/or reconstructive and cosmetic surgery.

Infertility Services

We will Cover Health Services related to the diagnosis and treatment of involuntary Infertility (included as part of basic health care services) that are ordered by and/or provided by a Par Doctor when the Infertility services are deemed Medically Necessary. Such services include, but are not limited to: intrauterine insemination (IUI), a form of artificial insemination, and standard fertility preservation procedures for women and men as recognized by the American Society of Clinical Oncology and/or American Society for Reproductive Medicine, for anyone facing the possibility of "iatrogenic infertility," which is Infertility caused by a necessary medical intervention, as well as Infertility drugs for Covered Infertility treatments administered in accordance with the benefit plan.

Excluded benefits include elective fertility preservation, such as egg freezing due to natural aging, long-term storage costs, Infertility treatments such as in vitro fertilization (IVF) that may be needed after necessary medical intervention, such as cancer treatment, to achieve a pregnancy. In addition, the following exclusions apply to fertile as well as infertile couples or individuals: assisted reproductive technology (ART) procedures, including IVF, embryo transfer and gamete intra-fallopian transfer (GIFT), and Zygote intra-fallopian transfer (ZIFT), as well as services related to the procurement, freezing or storage of sperm and eggs, ovum transplants, Infertility services when either Member of a family has been voluntarily surgically sterilized, services to reverse voluntary,

surgically induced Infertility, intravaginal insemination (IVI), Intracervical insemination (ICI), services for surrogate mothers who are not Plan Members, Preimplantation Genetic Diagnosis (PGD), or any services that are not FDA supported, or supported by evidence based guidelines.

General Exclusions

The following Health Services, including any and all services directly or indirectly related to or connected with them, regardless of when the injury or illness occurred, are not Covered.

1. Health Services which are not Medically Necessary. This includes services related to a condition for which treatment is not Medically Necessary.
2. Health Services which may be Medically Necessary but which are:
   A. considered not to be reasonable and necessary or any similar finding by: any government agency or subdivision (such as the FDA and the AHRQ); or by the CMS Medicare Coverage Issues Manual;
   B. not Covered under Medicare reimbursement laws, regulations or interpretations, on the basis that such are not reasonable and necessary or any similar finding; or
   C. not commonly and customarily recognized by informed health professionals in the United States as appropriate for the condition being treated.
3. Health Services rendered while you were not Covered under the Contract. This includes services provided before Coverage was effective and after Coverage ended.
4. Health Services:
   A. for which you have no legal obligation to pay;
   B. for which a charge would not ordinarily be made in the absence of Coverage under the Contract; or
   C. furnished under or as a part of a study, grant, or research program.
5. Health Services ordered or rendered by a Provider with the same legal residence as you or who is your spouse, brother, sister, parent, or child.
6. Charges for:
   A. failure to keep a scheduled appointment;
   B. telephone consultations from one provider to another provider; or
   C. completing a claim form or disability papers.
7. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or which arise solely due to a Provider's medical error are not Covered expenses ("Never Events"). Neither a finding of Provider negligence and/or malpractice, nor a judicial or administrative finding, is required for service(s) and/or fee(s) to be considered not Covered. PHP will determine whether a specific procedure, service or supply is Covered, including, but not limited to, whether charges are excluded because the cause is due to a Never Event.
8. Charges for services, care or procedures performed in or billed by a hotel, resort, educational institution (other than higher education student health clinics), vocational institution, residential setting, recreational setting or other non-conventional setting (including but not limited to health spas, yoga classes, health clubs, daycare institutions, outward bound programs, wilderness camp programs, ranch programs, halfway houses) even when prescribed by a Provider or services for medical or mental nervous conditions are provided.
9. Charges related to a specific condition for which you have refused to comply or have terminated the scheduled service or treatment against the advice of an attending Doctor.
10. Dental Care, dental implants, except for:
    A. Emergency dental treatment necessary to relieve pain and stop bleeding as a result of an accidental injury to natural teeth, if such treatment occurs within twenty-four (24) hours of the accidental injury;
    B. Dental Care services recommended by a Doctor and approved in advance in writing by PHP as necessary to safeguard your health from a specific non-dental impairment. A non-dental impairment is a medical condition not caused by dental disease but which may be worsened or its treatment complicated by the presence of dental disease. An example of such Covered Dental Care services is the removal of infected, carious teeth prior to an organ transplant.
11. Jaw surgery, such as but not limited to osteotomies for the correction of malocclusion, except if Covered elsewhere in the Contract and in accordance with our guidelines. Contact us for information regarding these guidelines.
12. Outpatient Prescription Drugs, self-administered Specialty Drugs (except Office Administered Specialty Drugs) and self-administered injectable drugs (except insulin), regardless of where they are administered, unless Covered elsewhere in this Contract.
13. Hearing aids and their fitting.
14. Eyeglasses and contact lenses and their fitting or routine eye examinations for refractive correction, unless

Covered elsewhere in this Contract; radial keratotomy and other refractive eye surgery; orthoptics and other eye exercises; vision training; subnormal vision aids; and other such services, supplies, or procedures intended to correct vision.

15. Removal of an organ or tissue from a Member for purposes of transplanting it into a person who is not Covered under the Contract.
16. Articles for common household use even if prescribed by a Provider such as but not limited to: air conditioners; humidifiers; dehumidifiers; air purifiers; allergenic pillows or mattresses; and water beds.
17. Cosmetic Procedures.
18. Personal comfort and convenience items and services or similar services, supplies and equipment, such as but not limited to: TV; phone; barber or beauty service; guest service; or meals on wheels.
19. Educational or vocational services primarily providing: training in the activities of daily living; work hardening; return to work programs; instruction in scholastic skills such as reading or writing; preparation for an occupation; or treatment for learning disabilities.
20. Long-term and maintenance therapy (treatment) and related follow-up evaluations. Services that are excluded from Coverage are those given when no further gains are clear or likely to occur including services that preserve the present level of functioning and prevent loss of functioning, but which do not result in any additional improvement. This exclusion does not apply to Habilitation Services as set forth elsewhere in this Contract.
21. Special articles of clothing.
22. Routine foot care such as but not limited to, the removal or reduction of corn and calluses or the clipping of nails, unless needed in the treatment of metabolic or peripheral-vascular disease.
23. Travel or transportation, even though prescribed by a Provider, except as provided elsewhere in the Contract.
24. Personal blood storage; replacing or donating blood or blood plasma, and associated services.
25. Autopsy.
26. Weight loss programs; appetite suppressants; behavioral modification; and services and supplies of a similar nature; except in accordance with our guidelines. Contact us for information regarding these guidelines.
27. Prescribed preparations or over-the-counter products such as: enteral feedings; supplements; vitamins; nutritional and electrolyte therapies. Specific nutritional products required to treat an inherited metabolic disease are Covered.
28. Non-Routine Immunizations, screening tests, vaccinations, exams or treatments, such as but not limited to services that:
    A. are related to judicial or administrative proceedings or orders;
    B. are conducted for purposes of medical research;
    C. are to obtain or maintain a license or official document of any type; or
    D. are to obtain, maintain, or otherwise related to education, travel, employment, insurance, marriage or Adoption.
29. Health Services or supplies related to alternative, complementary or integrative medicine or treatments that are not FDA approved to treat, diagnose, prevent or cure a medical condition such as but not limited to: acupuncture; biofeedback; hypnotism; megavitamin therapy; nutritional-based therapy for alcoholism or other Substance Use Disorder; psychosurgery; other forms of alternative treatments as defined by the Office of Alternative Medicine of the National Institutes of Health; and in accordance with our medical policy.
30. Cryotherapy; laser treatment; salabrasion; chemosurgery; or other such skin abrasion procedures that are:
    A. associated with the removal of scars or tattoos; and/or
    B. which are performed as a treatment for acne.
31. Growth hormone therapy for any condition that is not Medically Necessary.
32. Devices used as safety items or used to affect performance in sports-related activities or intended to improve appearance. All expenses related to physical conditioning, diversion, recreation, and general motivation, such as but not limited to: athletic training; body building; exercise; fitness; flexibility; home exercise equipment; health club memberships; personal fitness trainers; massage; seminars; tapes; and books.
33. Rating scales that measure behavior and attention span in the classroom and at home.
34. Orthopedic shoes or Orthotic supplies including, but not limited to: heel lifts; foot pads; and arch supports.

Shoes that are an integral part of a brace may be Covered as DME if approved in advance by PHP.

35. Health Services that are provided or payable under worker's comp, occupational disease, and similar laws, even if the Member's employer is not properly insured or self-insured under such laws. For example, if a Covered Person also farms for profit and is injured while farming, any expenses related to that injury are excluded under This Plan whether or not the farming business has or had workers compensation insurance.
36. Health Services related to marriage counseling.
37. Health Services related to learning disorders.
38. Custodial Care; Respite Care or rest cures; private duty nursing; or services received through a domiciliary care program.
39. Basic non-durable or disposable medical supplies available over the counter, prescribed or non-prescribed.
40. Devices that aid in communication where there is impairment such as but not limited to stuttering or loss of speech following a stroke. For example, a computerized display screen and/or keyboard/touch screen operated electronic voice synthesizer. Except that certain devices used by a Member with a laryngectomy or a permanent tracheostomy are Covered.
41. Experimental, Investigational, off label or Unproven services, treatments, supplies, devices, procedures, as well as drugs not approved by the FDA for the particular indication, unless the drug has been recognized as safe and effective for treatment of the health indication in one or more of the standard medical reference compendia adopted by the Department of Health and Human Services, or literature that meets certain criteria. The fact that the Experimental, Investigational or Unproven services, treatments, supplies, devices, procedures or drugs are the only option available for a particular condition will not result in Coverage.
42. Surrogate parenting (as a non-insured); home childbirth; and non-Medically Necessary amniocentesis.
43. Genetic Screening or Testing and genetic counseling. Except PHP Covers Certain Health Services that directly impact treatment or clinical decision making for the Member being screened, tested or counseled. PHP also Covers Certain Health Services consistent with the federal regulations on preventive care (see, Preventive Care benefit above).
44. Elective abortions shall in all instances be excluded, except when performed in accordance with state and federal law.
45. Donor fees associated with donor egg or donor sperm are not Covered, nor are services used in assisted reproductive technology procedures to achieve conception (e.g. ART, IVF, ZIFT, GIFT, etc.), as well as services related to the procurement, freezing or storage of sperm and eggs, ovum transplants, Infertility services when either Member of a family has been voluntarily surgically sterilized, services to reverse voluntary, surgically induced Infertility, intravaginal insemination (IVI), Intracervical insemination (ICI), services for surrogate mothers who are not Plan Members, Preimplantation Genetic Diagnosis (PGD), or any Infertility services that are not FDA supported, or supported by evidence based guidelines.
46. Any illness or Injury that occurs as a result of a riot, revolt, civil disobedience, nuclear explosion or a nuclear accident or any act of war, declared or undeclared, while serving in the armed forces.
47. Except as otherwise required by law or regulation, Health Services required while:
    A. incarcerated in a federal, state or local penal institution;
    B. in the custody of federal, state or local law enforcement authorities; or
    C. participating in a work release program.
48. A service, treatment, item or drug that is related to an approved clinical trial, except routine care costs incurred in the course of an approved clinical trial are Covered if Coverage would be provided for the same routine care costs not incurred in an approved clinical trial.
49. Health Services not Prior Authorized as required herein.
50. Notwithstanding anything to the contrary in this Certificate or an associated Declaration Page, charges or expenses provided or billed by, or through, Integrated Orthopedics, Blossom Bariatric Physicians or Warm Springs Surgical (Excluded Providers), as hereafter defined shall be excluded. For purposes herein, Excluded Providers shall include any predecessor, successor, affiliate, parent, subsidiary or any entity that has any common ownership with Excluded Providers, applying the attribution and constructive ownership rules of the Internal Revenue Code of 1986, and/or any entity that has a contractual relationship with Excluded Providers.
51. If a third party is directly or indirectly paid a referral or finder's fee, payment, reward or other remuneration, whether in cash or otherwise, by or on behalf of a Provider to encourage, direct, market or otherwise steer a Plan Member to use such Provider's services, any claim directly related to such services shall be denied.

Services by a Provider that PHP has determined uses abusive or fraudulent services and/or billing practices shall be excluded, unless the Provider can demonstrate that the services were Medically Necessary and billed in accordance with industry standards.

52. Referral to non-Par Providers for non-Emergency Health Services rendered outside of the United States and its Territories.
53. Services, supplies and Prescription Drugs related to male or female Sexual or erectile Dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing and/or services.
54. Surgical treatment of gynecomastia, unless it meets our guidelines.
55. Treatment of hyperhidrosis (excessive sweating), unless it meets our guidelines.
56. Treatment of hemangiomas and port wine stains, unless located on the head and neck areas for children ages 18 and under and it meets our guidelines.
57. The following Home Health Agency Services:
    A. food, housing, homemaker services and home-delivered meals;
    B. services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Agency;
    C. services provided by a Member of the Member's immediate family; or
    D. services provided by volunteer ambulance associations for which the Member is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.
58. Drugs related to a course of treatment or condition that are excluded or limited under the Contract.
59. Over-the-counter treatments, devices and drugs that are equivalent to an OTC medication, including vitamins.
60. Drugs obtained in excess of the Contract's dispensing limitations.
61. Prescription Drugs dispensed more than one year from the date of the Prescription.
62. Biological sera; blood; or blood plasma are not Covered under the pharmacy benefit.
63. Drugs and products used for weight loss or appetite suppression, unless prescribed for narcolepsy or hyperkinesia.
64. Injectable drugs that are not self-administered are excluded from Coverage under the pharmacy benefit.
65. Drugs and supplies for cosmetic purposes only such as but not limited to:
    A. Propecia or topical Minoxidil to promote hair growth;
    B. anabolic steroids to enhance physical appearance or athletic performance; and
    C. Tretinoin (Renova) when used to treat wrinkled or photo-aged skin.
66. Replacement Prescription Drugs of a filled Prescription due to loss; breakage; theft; or discard.
67. A Prescription Drug Product for which any required Step Therapy has not occurred.
68. Prescription Drugs and Self-Administered Specialty Drugs received from a non-Par Pharmacy.
69. Extended release tetracyclines such as but not limited to: Solodyn, Doryx, Adoxa, or Oracea.
70. Prescription Drugs acquired and/or purchased outside of the United States and its Territories unless approved before acquired.
71. Behavioral Health and Mental Health and Substance Use Disorder Services or other services provided for purposes of general counseling or advice, which are not Medically Necessary or that extend beyond the period necessary for evaluation, diagnosis, or crisis intervention as follows:
    A. conditions not classified in the ICD or DSM;
    B. behavior disorders not related to Behavioral Health and Mental Health or Substance Use Disorder;
    C. testing for attention deficit/hyperactivity disorder;
    D. intellectual disabilities or non-treatable mental deficiencies;
    E. conditions which according to generally accepted professional standards are not usually open to favorable modification; or
    F. anti-social behavior without evidence of a psychiatric disorder.
72. Psychiatric or psychological examinations, testing or therapies that are related to judicial or administrative proceedings or orders.
73. Vagus Nerve Stimulator unless otherwise authorized and in accordance with PHP's medical policies.

General Enrollment Conditions

The Group is responsible for determining eligibility for enrollment, Coverage classification changes and termination of eligibility for Coverage in accordance with terms of the Contract. PHP, however, reserves the right to investigate and confirm an individual's initial or ongoing eligibility and terminate coverage if PHP determines, in its sole discretion, that an individual was or is not eligible.

Eligible Persons may enroll themselves and their eligible Dependents in PHP during an Open Enrollment Period. We will not deny your enrollment for health reasons. We will not place any limitations on your eligibility or continued eligibility due to a health factor.

With regard to eligibility, we shall not:

A. request, require, inquire or purchase the results of your Genetic Screening or Testing;
B. request or require you to submit to Genetic Screening or Testing;
C. use the results of Genetic Screening or Testing to determine eligibility for enrollment, Premium or contribution amounts; or
D. make an adverse decision against you based on the results of your Genetic Screening or Testing.

Except as set forth in this section, Eligible Persons and/or their Dependents may not enroll without our written approval. Subscribers must apply on an Enrollment Form we have approved.

If the Group is an "applicable large employer," as defined by the ACA, the following provisions shall apply for purposes of determining full-time employees:

New Hires

A. *Regular Full-time Employees* means employees designated by the Group as *Regular Full-time Employees.* Coverage for *Regular Full-time Employees,* if properly elected, will be effective as of the date set forth in the Contract, but in no event later than the 91st day of Full-time Employment.

B. *Seasonal, Variable hour or Part-time Employee* means employees, including but not limited to variable hour, part-time or seasonal employees ("Qualifying Employee"), who are not Regular Full-time Employees because, in good faith, the Group cannot determine such Employees will average thirty (30) hours of service per week over the employee's applicable Initial Measurement Period, and do not meet or exceed thirty (30) hours per week during the Initial or Standard Measurement Period (and are not otherwise excluded). Coverage for a Qualifying Employee, if properly elected, will be effective on the first day of the Qualifying Employee's New Employee Stability Period. A Qualifying Employee will remain eligible throughout the Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules.

If there is a gap between the end of the Qualifying Employee's New Employee Stability Period and the start of the Qualifying Employee's first Ongoing Employee Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period to the extent the employee remains employed, subject to the Plan's Break in Service rules.

If a Qualifying Employee transfers to a Regular Full-time Employee position prior to the start of the Qualifying Part-time Employee's New Employee Stability Period, the employee will become eligible for coverage. If elected, coverage for such new Regular Full-time Employee will become effective following the later of the end of the waiting period set forth above (treating all service as if a Full-time Employee) or the 1st of the month following the date such individual is designated a Full-time Employee.

"Ongoing" Employees

Eligibility

Once an employee has completed the Group's Standard Measurement Period, eligibility will be based solely on the employee's Hours of Service during the Standard Measurement Period. Any employee who averages thirty (30) Hours of Service per week during the Group's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period to the extent that the Ongoing Employee remains employed, subject to the Group's Break in Service rules. Such coverage, if elected, will be effective on the first day of the Group's Ongoing Employee Stability Period.

Whether an employee averages thirty (30) Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Measurement/Administrative/Stability Periods: Except as otherwise established by the Group in writing and approved in advance by PHP:

A. Newly Hired Qualifying Employees – Twelve (12) month measurement period beginning on the first day of the month coincident with or following the date of hire, followed by a thirty (30) day administrative period and a twelve (12) month stability period.

B. Ongoing Employees – Twelve (12) month measurement period ending at the end of the month at least sixty (60) days prior to the first day of the following plan year, followed by a sixty (60) day administrative period, and a plan year stability period; or

   If a part-time, variable hour or seasonal employee averages at least thirty (30) hours during the measurement period, then the employee may enroll for the following stability period regardless of hours.

Hour of Service: An "hour of service" is an hour for which the employee is a common law employee of the Group or a related employer and the employee is:

A. For hourly employees, each hour:
   1) paid or entitled to pay for performance of duties for the Group or a related Group; or
   2) paid or entitled to pay for any period during which the employee does not perform any duties due to vacation, holiday, illness, incapacity (including short-term disability), layoff, jury duty, military duty or a company-approved leave of absence.
B. If the employee is not paid hourly, the employee will receive credit for eight (8) hours of service for each day on which he/she performs duties for the Group or a related Group, or paid or entitled to pay for any period during which the employee does not perform any duties due to vacation, holiday, illness, incapacity (including short-term disability), layoff, jury duty, military duty or a company-approved leave of absence.
C. No service will be credited for an hour of service during any period in which:
   1) the employee is not a common law employee of the Group or a related Group; or
   2) the employee is an independent contractor or leased employee.

Leave: For eligibility purposes during a measurement period, while an employee is on a paid or unpaid company-approved leave for USERRA, FMLA and jury duty, his/her average hours worked during the portion of the measurement period when he/she was not on leave will be credited for each full week of the leave (or prorated for each partial week of leave) for the purpose of determining whether he/she is an eligible part-time employee under the Plan.

Breaks in service exceeding 13 weeks: If the employee terminates employment with the Group or a related Group, does not perform any services for at least 13 consecutive weeks and then resumes employment with the Group or a related Group, the employee will be considered a new employee. In that case, the Group will determine whether the employee is an eligible employee based on the circumstances at the time of rehire. If the Group determines that the employee is not an eligible full-time employee when employment resumes, a new initial measurement period will apply and the employee will become an eligible part-time employee only if he/she works an average of thirty (30) hours per week during the new initial measurement period or any standard

measurement period that begins after employment recommences. If the Group is an educational institution, 13 weeks shall be replaced with 26 weeks.

Breaks in service of less than 13 weeks: If an employee resumes employment with the Group or a related Group within 13 weeks after the date the employee was last credited with an hour of service, and he/she was an eligible employee during the most recent measurement period prior to termination of employment, the employee will remain eligible and may re-enroll in the Plan with the same level of coverage (or less) on the date employment resumes. If the employee had not completed the initial measurement period prior to terminating employment, the initial measurement period will resume. Employee shall be credited with zero (0) hours for period of separation. If the Plan Sponsor is an educational institution, thirteen (13) weeks shall be replaced with twenty-six (26) weeks.

Corrective Action: If, at any time, the Plan Administrator determines that an employee became an eligible part-time employee during the previous applicable measurement period, but was not offered an opportunity to enroll, it may, but need not, deem the employee and dependent children to have elected coverage as of the date coverage should have started. Once it determines the employee was an eligible employee and decides to offer retroactive coverage, it will notify the employee of eligibility and offer an opportunity to enroll and any dependents as of the date the employee first became eligible. In that case, the employee will have an opportunity to submit any covered medical expenses for reimbursement subject to the terms of the Plan, and the Plan will waive any Premiums for the period of coverage prior to the date the employee is notified of eligibility to enroll.

This document is primarily intended to identify "full time" employees for ACA reporting purposes. Although a Group may use the above to determine eligibility, the Contract sets forth eligibility requirements and exclusions, and controls in the event of a conflict.

Interpretation/Administration: The foregoing provisions shall be interpreted and administered in accordance with the ACA. The Group may adopt procedures to further administer eligibility provisions.

Newly Eligible Person Enrollment

Employees newly eligible for coverage will have an opportunity to enroll during an initial enrollment period. Timing of the effective date of such Coverage will be based on the waiting period your Group requires. This waiting period cannot exceed ninety (90) days. Coverage for a newly Eligible Person shall take effect on the date of eligibility if:

A. the Eligible Person completes an Enrollment Form within thirty-one (31) days after the date of eligibility;
B. the Group forwards the Enrollment Form to PHP within sixty (60) days after the date of eligibility; and
C. the Group pays any applicable Premium.

If you are a newly Eligible Person and you do not enroll yourself and your Dependents during the timeframe explained above, you must wait to enroll until the next Open Enrollment Period or during a Special Enrollment Period.

New Dependent Enrollment

Newborn children are automatically Covered from the moment of birth up to thirty-one (31) days. Adopted children or children placed for Adoption are automatically Covered on the date of Adoption or placement for Adoption, whichever is earlier. After thirty-one (31) days from birth, Adoption or placement for Adoption, Coverage for these children will end unless:

A. the Subscriber completes and provides the Group with a change form to enroll the new Dependent within thirty-one (31) days of the birth, Adoption or placement for Adoption;
B. the Group forwards the change form to PHP within sixty (60) days of the applicable event; and
C. the Group pays any applicable Contract Charge.

Enrolled Dependent Coverage for a child placed for Adoption ends on the date the child is removed from

placement if placement is disrupted prior to legal Adoption.

Enrolled Dependent Coverage for a new Dependent obtained through legal acquisition (guardianship and/or custody) is effective on the date of the event if:

A. the Subscriber completes and provides the Group with a change form to enroll the new Dependent within thirty-one (31) days of the legal acquisition;
B. the Group forwards the change form to PHP within sixty (60) days of the legal acquisition; and
C. the Group pays any applicable Contract Charge.

Special Enrollment

If a person does not enroll during the initial enrollment opportunity or during Open Enrollment, he/she may be able to enroll under certain circumstances. This is called special enrollment.

Under federal law an Eligible Person and his/her Dependents have special enrollment rights when:

A. An Eligible Person acquires a new Dependent through marriage, birth, Adoption or placement for Adoption.

   The Eligible Person may enroll:
   1) himself/herself;
   2) a legally wedded spouse; and/or
   3) the newly-acquired eligible Dependents;

   on the date the new Dependent is acquired through marriage, birth; Adoption or placement for Adoption. To do so, the Eligible Person must notify the Group within thirty (30) days of the marriage, birth, Adoption or placement for Adoption. The Group must then forward the applicable change form to PHP within sixty (60) days of the applicable event and timely pay any applicable Premium.
B. An Eligible Person and/or his or her Dependents were covered under another health plan or other Minimum Essential Coverage during an Open Enrollment Period but lost such coverage. To enroll, the Eligible Person and/or his or her Dependents must:

   1) notify the Group within thirty (30) days of losing such other coverage; and
   2) document that such loss was due to:
      (a) losing eligibility as a result of:
         (1) termination of employment;
         (2) a reduction in the number of work hours;
         (3) a divorce or legal separation;
         (4) a dependent that is no longer eligible;
         (5) the death of an employee or spouse;
         (6) no longer living or working in a previous plan's service area;
         (7) meeting or exceeding a lifetime maximum on all benefits;
         (8) benefits no longer being offered to a particular class of individuals;
      (b) the exhaustion of COBRA continuation coverage;
      (c) an employer stopping contributions toward employee or dependent coverage;
      (d) the involuntary termination of the health plan; or
      (e) a change in status, if the Contract is purchased as a cafeteria plan subject to Section 125 of the Internal Revenue Code.

   For Coverage to become effective, the Group must provide us with a completed Enrollment Form within sixty (60) days of such loss of coverage and pay the applicable Premium. In such cases, Coverage will, generally, be effective on the day of loss of coverage. Loss of other coverage does not include termination or loss due to the failure to pay Premiums, including COBRA Premiums prior to the expiration of COBRA coverage, or circumstances permitting for rescission such as fraud or intentional misrepresentation of material fact.
C. An Eligible Person and/or his or her Dependents may enroll if:
   1) the Eligible Person and/or his or her Dependent's coverage under Medicaid or CHIP is terminated

as a result of loss of eligibility and the Subscriber notifies the Group and requests Coverage within sixty (60) days after such termination; or

2) the Eligible Person and/or his or her Dependent's become eligible for a premium assistance subsidy under Medicaid or CHIP and the Subscriber notifies the Group and requests Coverage within sixty (60) days after the eligibility determination date.

For Coverage to become effective, the Group must timely provide us with a completed Enrollment Form and pay the applicable Premium.

D. An Eligible Person who is ordered by a QMCSO to provide health coverage to a child may enroll himself/herself and such child under the Contract. If the Eligible Person fails to enroll the child, the following may apply for Coverage for the child:
   1) the child's custodial parent;
   2) the Office of Medicaid Policy and Planning; or
   3) a Title IV-D agency.

   We shall not deny enrollment of a Dependent child pursuant to a QMCSO on the basis that the Dependent child:
   1) was born out of wedlock;
   2) is not claimed as a Dependent on the Subscriber's federal income tax return;
   3) does not reside with the Subscriber; or
   4) does not reside within our Service Area.

   Coverage shall be effective on the date the order is determined to be a QMCSO. The Group must timely provide us with a completed Enrollment Form and pay the applicable Premium.

   PHP may not disenroll a Covered Dependent child pursuant to a QMCSO until he or she is no longer eligible due to reaching the limiting age without satisfactory proof that:
   1) the order is no longer in effect; or
   2) the child is or will be enrolled in comparable health coverage that is to take effect not later than the date of disenrollment.

E. An Eligible Person who is required to provide Coverage for a Dependent child because of a court order or administrative order may enroll the Dependent child under the Contract if:
   1) the order is signed by the court;
   2) the Subscriber is already enrolled;
   3) the Subscriber completes a change form within thirty-one (31) days (or any such longer period permitted by the Group up to a maximum of sixty (60) days) after the court order or administrative order is signed by the court;
   4) the Group forwards the change form to PHP within sixty (60) days after receipt of the order; and
   5) the Group pays any applicable Premium.

   Coverage shall become effective:
   1) the date indicated in the order; or
   2) the date the court signs the order, if the order does not specify an effective date.

   Coverage shall end for the Dependent child on the earliest of:
   1) the date the Subscriber's Coverage ends;
   2) the date the order is no longer in effect; or
   3) the date the Dependent child reaches the limiting age.

Notification of Enrollment Changes

The Group shall notify us in writing within sixty (60) days of the effective date of enrollments and terminations. The Group shall notify us in writing each month of any Coverage classification changes and qualifying events which would include, but is not limited to, any qualifying events for purposes of COBRA continuation Coverage.

Effective Date of Coverage

Unless otherwise specified by this section, Coverage for an Eligible Person and his or her Enrolled Dependents, if any, is effective on the date specified by the Group and PHP.

Enrollment is subject to PHP receiving a properly completed Enrollment Form. No Coverage shall be effective until the Contract takes effect. No Dependent shall be Covered until the Eligible Person is Covered.

Service Area Requirements

Members must live or work in the Service Area unless we approve other arrangements. If the Member meets the requirements by working in the Service Area, he or she may reside outside the Service Area, provided Covered Health Services are received from Participating Providers for In-Network Benefits, except for:

A. Emergency Health Services; or
B. Referral Health Services.

If a Member resides outside of the Service Area, he or she must obtain Health Services from In-Network Par Providers to be Covered at In-Network Benefits.

Prior Authorization of Certain Health Services

To avoid the risk of non-Coverage of the following Health Services, PHP must give its Prior Authorization before you receive these Certain Health Services. You must identify yourself as a Member before receiving Health Services so that the Par Provider can follow required Prior Authorization procedures. If PHP procedures are not followed as a result of your failure to identify yourself as a Member, benefits may be denied. Prior Authorizations are subject to the terms, limitations and exclusions set forth in the Contract.

Prior Authorizations help determine when services are Medically Necessary or Experimental/Investigational and assist in the review of level of care and place of service that services are performed. The following list is not the full list of Health Services that require Prior Authorization to be Covered by PHP. Par Providers have received information from us regarding the Health Services that require Prior Authorization and typically will request Prior Authorizations as needed.

Our Customer Service Department can answer questions you may have about whether a particular Health Service requires Prior Authorization. You may also check our website (www.phpni.com) for the full list of Health Services requiring Prior Authorization. To obtain Prior Authorization or additional information, contact our Customer Service Department at: (260) 432-6690, ext. 11, or (800) 982-6257, ext. 11.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be Covered, on the date you get service:

A. You must be eligible for benefits;
B. Premium must be paid for the time period that services are given;
C. The service or supply must be a Covered service under your Plan;
D. The service cannot be subject to an exclusion under your Plan; and
E. You must not have exceeded any applicable limits under your Plan.

In addition to meeting other requirements of the Contract, the following Certain Health Services require PHP's Prior Authorization for both In-Network and Out-of-Network Benefits Coverage:

A. radiology services, such as but not limited to PET scans, CT scans, MRI/MRA scans, nuclear cardiology, nuclear medicine and 3D imaging;
B. inpatient Health Services (facility and professional charges);
C. Home Health Care;
D. Hospice Care;
E. certain Durable Medical Equipment, prosthetics and orthotics;
F. Transplant services (except corneal transplants);
G. Outpatient services including sleep studies, out-of-network Referrals, and behavioral health testing;
H. certain surgical and reconstructive procedures;
I. select Specialty Drugs and opioids – for a complete listing, please refer to our website (www.phpni.com);
J. temporomandibular or craniomandibular joint disorder and craniomandibular jaw disorder services;
K. select outpatient surgical or medical procedures as determined by us;
L. services at a residential treatment center;
M. Genetic Screening or Testing; and
N. Referrals to non-Par Providers.

Reviewing where Services are Provided

A service must be Medically Necessary to be a Covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, may not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. A request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

A. A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital;

B. A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a physician's office
C. A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a requested treatment is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Customer Service (260) 432-6690, ext. 11 or (800) 982-6257, ext. 11 or the Prior Authorization phone number on the back of your PHP ID card.

Types of Review

Pre-Service Review: A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

Precertification (also referred to as Prior Authorization or Prior Approval): A required Pre-Service Review for a benefit Coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit Coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational.

For admissions following Emergency care, you, your authorized representative or Doctor must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time.

For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48 hours for vaginal delivery or 96 hours for caesarean require Precertification.

Continued Stay/Concurrent Review: A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews will be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Either you, the treating Provider or any Physician with knowledge of your medical condition can request an urgent Pre-Service or urgent Continued Stay/Concurrent Review of a service, treatment or admission for a benefit coverage determination, including for a Prescription Drug that is going to be used for the treatment of opioids. Please note that where a Pre-Service or Continued Stay/Concurrent Review request is required for Medication Assisted Treatment for the treatment of opioids, such requests will be considered urgent. Urgent reviews are conducted under a shorter timeframe than standard reviews. If an urgent review request is not approved, the Member may proceed with an expedited external review while simultaneously pursuing an Appeal through our internal Appeal process. If a Continued Stay Review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited external review while simultaneously pursuing an Appeal through our internal Appeal process.

Post-Service Review: A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us. An example of a type of post service review is a retrospective post-claim review. For retrospective

reviews if you send us a written request, we will permit a retrospective review for a claim that is submitted where Precertification was required but not obtained if the service in question meets all of the following:

A. The service is directly related to another service for which Precertification has already been obtained and that has already been performed;
B. The new service was not known to be needed at the time the original Prior Authorized service was performed;
C. The need for the new service was revealed at the time the original authorized service was performed.

Once we have received the written request and all necessary information, we will review the claim for coverage and Medical Necessity. We will not deny a claim for such a new service based solely on the fact that we did not receive a Precertification approval for the new service in question.

Request for Benefits Notification Requirement

PHP will review Prior Authorization requests in accordance with the timeframes below, which are based on federal and state laws.

Non-Urgent Pre-Service	Two (2) business days from receipt of the request
Urgent Pre-Service requests	For requests submitted via fax or telephone, we will respond in seventy-two (72) hours or two (2) business days from PHP receiving the request. For requests submitted electronically, we will respond within forty-eight (48) hours of PHP receiving the request
Non-Urgent Concurrent Reviews	One (1) business day from PHP receiving the request
Urgent Concurrent Reviews	If the request is received more than twenty-four (24) hours before the end of the current authorization, PHP will response within twenty-four (24) hours of the receipt of the request. If the request is received in less than twenty-four (24) hours before the end of the previous authorization, PHP will respond within seventy-two (72) hours or one (1) business day, whichever is less, from the receipt of the request.
Post-Service Reviews	PHP will respond to post service reviews within thirty (30) days from the receipt of the request.

In some instances, more information may be needed for PHP to make a determination. When that occurs, we will inform the Provider of the specific information that is needed to complete the review. If the provider does not submit the information needed by the required timeframe we will make our determination based on the information we have. We will notify you and your Provider of our determination as required by state and federal law. Following our review, we will inform you in writing whether the services are authorized for Coverage. We may inform you electronically, verbally or in writing. Our notification will state if the request is approved or denied. If PHP denies, we will provide the specific reason for the denial.

Electronic Submission of Pre-Service Reviews

Pre-Service Reviews may be submitted electronically. If the Pre-Service request for service or drugs is submitted to PHP electronically from the provider, we will respond:

- Urgent Care Services – within forty-eight (48) hours of the time PHP receives the request;
- Non -urgent or non-emergent services – within ten (10) calendar days from the date PHP receives the request for services

Our response will include a determination of whether the service is approved or denied. If we deny a request for service, we will provide the reason for the denial. If the request received by PHP is incomplete, we will indicate the specific additional information that is required to process the request. If PHP requests additional information required to review the request, your Provider must provide an electronic receipt to us acknowledging that the request for additional information was received

Once a Pre-Service Review is approved based upon the complete and accurate submission of all necessary information, it will not be retroactively denied if the Provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the Provider's contract with us.

A PHP Prior Authorization does not guarantee Coverage for the Health Service or procedure reviewed. Benefits of the Contract are determined in accordance with all of the terms; conditions; limitations; and exclusions.

IN-NETWORK CONDITIONS

Health Services by Par Providers

Health Services rendered by Par Providers are Covered as In-Network Benefits if:

A. ordered by a Par Doctor (including Health Services performed at Par facilities);
B. provided by or under the direction of a Par Provider;
C. Medically Necessary; and
D. the Contract specifies such services as Covered.

The Par Provider is required to continue to provide covered health care services to Members in the event of PHP's insolvency or discontinuance of operations. The Par Provider is required to continue to provide covered health care services to Members as needed to complete any Medically Necessary procedures commenced but unfinished at the time of PHP's insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all covered health care services that constitute Medically Necessary follow-up care for that procedure.

The provision above shall not require the Par Provider to continue to provide any covered health care service after the occurrence of any of the following:

A. The end of the thirty (30) day period following the entry of a liquidation order under ORC 3903;
B. The end of the Member's period of coverage for a contractual prepayment or Premium;
C. The Member obtains equivalent coverage with another health insuring corporation or insurer, or the member's employer obtains such coverage for the Member;
D. The Member or the Member's employer terminates coverage under the contract;
E. A liquidator effects a transfer of PHP's obligations under the contract under division (A)(8) of section ORC 3903.21.

Verification of Participation Status

You must check to see that the Provider is a Par Provider before receiving Health Services.

You must show the Provider your PHP I.D. card before receiving Health Services. If you do not show your card to a Provider, they have no way of knowing that you are a Member and have no way to bill us.

If you do not identify yourself to the Provider as a Member within one year from the date Health Services are incurred:

A. a Provider may bill you for your Health Services; and
B. you shall be responsible for 100% of the cost of your Health Services.

The Provider also needs to know that you are a Member in order to follow PHP procedures, such as a Prior Authorization. If the failure to show your I.D. card results in non-compliance with required PHP procedures, we

will deny Coverage. You shall be responsible for 100% of the cost of your Health Services.

Referral to non-Par Providers

The Eligible Expenses of non-Emergency Health Services provided by non-Par Providers will be Covered as In-Network Benefits if:

A. the Health Services cannot be provided by or through Par Providers;
B. the Health Services are Medically Necessary;
C. a Par Doctor Referred you to the non-Par Provider;
D. the Health Services are specified as Covered by the Contract;
E. the Health Services are rendered in the United States and its Territories; and
F. we have approved the Referral in writing before you receive the Health Services.

You must satisfy all of the above requirements and PHP must approve the Referral, in advance, before receiving non-Emergency Health Services ordered or provided by a non-Par Provider if such services are to be Covered as In-Network Benefits. If you do not:

A. the cost of such services will be Covered as Out-of-Network Benefits, if applicable; or
B. you will be responsible for all costs of such services if such services are not Covered.

Additional Health Services not authorized in the original Referral require a new Referral.

Emergency Health Services

We will Cover Eligible Expenses for Emergency Health Services as an In-Network Benefit, whether rendered by Par or non-Par Providers. Such services must be:

A. provided during the course of an Emergency;
B. Medically Necessary for evaluating and treating an Emergency condition, up to the point of Stabilization; and
C. provided by or under the direction of a Provider.

In-Network Benefits are paid for Emergency Health Services rendered by non-Par Providers only until your condition is Stabilized, as determined by PHP. Once Stabilized, any additional Health Services you need must be provided by Par Providers in order to obtain In-Network Benefits for such services.

If we determine that the situation was not an Emergency, as defined by the Contract, including services provided outside of the United States and its Territories, such non-Emergency Services are not Covered.

Inpatient Emergency Health Services by non-Par Providers

If you are Hospitalized in a non-Par facility due to an Emergency, you must notify us within forty-eight (48) hours after the time the Hospitalization commences following the Emergency Health Services (or as soon thereafter as is reasonably possible) to be Covered as an In-Network Benefit. You must make available full details of the Emergency Health Services received, at our request.

To continue to be Covered as an In-Network Benefit, your continued stay in a non-Par facility after your condition is Stabilized and is no longer an Emergency requires:

A. coordination by a Par Doctor; and
B. our prior written authorization.

We may elect to transfer you to a Par Hospital once it is medically appropriate to do so. If you choose to remain in the non-Par facility after we have notified you of our intent to transfer you to a Par facility, further Health Services rendered by non-Par Providers are Covered as Out-of-Network Benefits.

Continuing Par Provider Care for Certain Health Conditions

If you are a continuing care patient, as defined below, and receiving services or are Hospitalized in a Par facility and your benefits are terminated for any of the following events, you are entitled to certain rights with respect to your continuing care. The events that can trigger your continuing care rights are:

A. The termination or expiration of the Par Provider's Contract with PHP unless the Contract was terminated because of failure of the Par Provider to meet PHP's quality standards or due to fraud by the Par Provider;
B. A change in the terms of the Par Provider's Contract with PHP that results in termination of the benefits provided under the Contract; or
C. The termination of the Contract which results in the loss of benefits provided under the Contract.

In the event you are entitled to continuing care rights, you are entitled to the following:

A. PHP will notify you on a timely basis of your right to elect continuing transitional care;
B. You can elect to receive transitional care as you would have received before the event that triggered your continuing care rights. Your transitional care rights begin on the date on which you receive the required notice from PHP and end on the earlier of the end of the ninety (90) day period beginning on the date you receive the required notice and the date you no longer qualify as a continuing care patient.

A continuing care patient is defined as an individual who, with respect to a Par Provider:

A. is undergoing a course of treatment for a serious and complex condition, as defined below, from the Par Provider;
B. is undergoing a course of institutional or inpatient care from the Par Provider;
C. is scheduled to undergo nonelective surgery from the Par Provider, including receipt of postoperative care from such Par Provider with respect to such a surgery;
D. is pregnant and undergoing a course of treatment for the pregnancy from the Par Provider; or
E. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such Par Provider.

A serious and complex condition is defined as:

A. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
B. in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a pro-longed period of time.

Access to Health Services

Additional information on access to Health Services can be obtained through:

A. our Par Provider Directory;
B. our Member newsletter; and
C. our Customer Service Department as follows:
   - (260) 432-6690, Extension 11;
   - (800) 982-6257, Extension 11;
   - (260) 432-0493 (fax);
   - custsvc@phpni.com (e-mail); or
   - www.phpni.com.

OUT-OF-NETWORK CONDITIONS

Health Services Obtained from non-Par Providers

Non-Emergency and non-Referral Health Services rendered by non-Par Providers are Covered as Out-of-Network Benefits if:

A. ordered by a non-Par Doctor (including Health Services performed at non-Par facilities);
B. provided by or under the direction of a non-Par Provider;

C. Medically Necessary; and
D. the Contract specifies such services as Covered.

Refer to the Schedule of Benefits for specific benefit information. Under Out-of-Network Benefits, if a portion of a Provider's charge exceeds the Reasonable and Customary Charge, that amount is not considered an Eligible Expense and is your sole responsibility. You may contact us for information about Reasonable and Customary Charges under Out-of-Network Benefits.

A copy of all medical bills should be submitted to PHP.

Notice of Pregnancy

When you obtain Maternity Health Services under Out-of-Network Benefits, you should notify us of your Pregnancy as soon as possible, but no later than one (1) month before your anticipated due date. This allows us to:

A. pre-authorize all Health Services for which this section requires such authorization; and
B. provide, as needed, maternity-related assistance to you.

If a Provider, facility, or anyone else waives, discounts, reduces, or indirectly pays the required cost sharing (Deductible, Copays, Coinsurance) for a particular claim, we reserve the right to adjust the amount charged, the amount eligible under the terms of the policy, your Deductible, and/or your Out-Of-Pocket Limit, to accurately reflect the amount actually charged for that claim.

The Contract does not pay for all Health Services you may receive. Benefits are limited to Covered Health Services. You must meet any applicable deducible and pay any required Copays and/or Coinsurance for most Covered Health Services. You must pay the full cost of all Health Services that are not Covered by this Contract.

Par Provider Services

Par Providers are responsible for submitting claims to us on your behalf for Health Services they render. We shall reimburse the Par Provider directly for Covered Health Services. The amount of the reimbursement shall be the lesser of the Par Provider's billed charge or the payment amount the Par Provider has agreed to accept as full reimbursement under our contract with the Par Provider. Because Par Providers have agreed to accept such reimbursements as payments in full, they should not attempt to bill or collect from you any amounts that may exceed the lesser of our Payment or the agreed-upon reimbursements. You may still have to make a payment to the extent you have not met the applicable Deductible or you have a Copay or Coinsurance obligation.

You are responsible, as required by the Contract, for the Copays/Coinsurance; and/or Deductibles; and the cost of Health Services that are not Covered by this Contract.

You should contact us if you are billed by a Par Provider for Eligible Expenses of Covered Health Services other than Copays/Coinsurance and/or Deductibles.

Non-Par Provider Services

Processing and payment of eligible claims and determination of Members cost sharing, including application of In-Network Benefits (provided by PHPNI) and Out-of-Network Benefits (provided by PHPIC), will be administered in accordance with all applicable Federal and State laws, including, but not limited to, the No Surprise Bill Act, and applicable guidance issued by appropriate regulatory agencies.

You are responsible for selecting the providers and other healthcare professionals who will deliver your care. If we have not contracted with Providers or if we have contracted with Par Providers with respect to other products but not this particular product, then such Providers are non-Par Providers. The fact that a Par Provider or other healthcare professional has suggested or arranged for you to receive Health Services from a non-Par Provider or other non-Par health care professional does not make such services Covered as an In-Network Benefit under this Contract.

When we reimburse non-Par Providers, we will reimburse non-Par Providers based on a "Reasonable and Customary Charge," which is a fee for a Covered Health Service that is, in our discretion, one of the following:

A. an amount based on a non-Par Provider Fee Schedule we created in our discretion. We can modify, from time to time, this schedule if we consider it appropriate after considering one or more of the following: reimbursements similar to those we have with like Par Providers, reimbursements paid by the Centers for Medicare and Medicaid Services (CMS) for the same services and/or supplies, or other applicable industry cost, reimbursement or utilization data;
B. any negotiated payment amount we have with a non-Par Provider, either through our own contract or that of a third-party vendor;
C. an amount based on CMS' reimbursements, by level or method, for the same service or supplies;
D. an amount based on information from a third-party vendor(s), which may take into account one or more of the following factors: the treatment's complexity or severity, the skill and experience level necessary for the treatment, or comparable providers' costs to deliver similar care; or
E. if less than all of the above, the amount billed by the non-Par Provider.

Reimbursement

The amount we pay a non-Par Provider may not satisfy, in full, the charges sought by such provider. It may send you a bill and collect on any balance owed, assuming we made a payment at all. It is your responsibility to pay the balance, which can be significant. Choosing a Par Provider will likely result in cost savings and lower out-of-pocket costs to you. For Covered Emergency and Referred Health Services, you are responsible for the Copay/Coinsurance and/or Deductible required by the Contract for similar Health Services provided by a Par Provider. You should not be balanced billed for these types of services.

Our Customer Service Department is available to help you find a Par Provider and can be reached at any of the following:

(260) 432-6690, Extension 11;
(800) 982-6257, Extension 11;
(260) 432-0493 (fax);
custsvc@phpni.com (e-mail); or
www.phpni.com.

You must submit claims to us for all Health Services rendered by non-Par Providers within ninety (90) days of the service. You must give us all of the information we need to process such claims. If you do not provide this information, you may not be paid.

We will accept your request after ninety (90) days if it was not reasonably possible to submit it within that time. We will not make any payment if the request and proof of service is submitted to us more than twelve (12) months after the date of service. However, these limits will not apply while you lack legal capacity.

We will pay all Eligible Expenses for Covered Health Services to the Subscriber. With written authorization from the Subscriber, all or a portion of the Eligible Expenses due may be paid directly to the non-Par Provider.

You are responsible for the Copays/Coinsurance and/or Deductibles required by the Contract and for the cost of all Health Services that are not Covered by the Contract.

Filing a Claim for non-Par Provider Services

Claims must be submitted in English. When a claim is not submitted in English, both the original claim and the claim translated in English must be submitted to PHP. Any cost associated with an English translation is your responsibility. Submit your claim to:

Physicians Health Plan of Northern Indiana, Inc.
Claims Department
PO Box 2359
Fort Wayne, IN 46801-2359

Be sure your claim includes the following information:

A. your name and address;
B. patient's name; date of birth; and Member I.D. number (shown on your identification card);
C. name and address of the Provider of services;
D. diagnosis from the Doctor;
E. itemized bill which gives a CPT code, or description of each charge; and
F. date the Injury or Sickness began.

Note: Some claims may require more information before being processed. Benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

Incurred Charge Date

Benefits under the Contract are based upon the benefits in effect on the date a charge is incurred. A charge is incurred on the date the Health Services are performed.

Coverage through non-Custodial Parent

Whenever a child under the age of 18 is an Enrolled Dependent under the Contract through a non-custodial parent, we shall upon the custodial parent's written request:

A. provide any information to the custodial parent that is necessary for the child to obtain benefits through the Contract;
B. permit the custodial parent, or the Provider with the custodial parent's approval, to submit claims for Covered Health Services without the non-custodial parent's approval; and
C. pay claims submitted by the custodial parent or the Provider in accordance with B. above, directly to the custodial parent, Provider, or Office of Medicaid Policy and Planning, as appropriate.

Medicaid

The state Medicaid program is considered to have been assigned your rights to payment for Health Services, if it has paid for such services. We cannot impose different requirements on a state Medicaid agency that has been assigned your rights than those we would impose on any other agency or assignee of any other Member.

Payment of Claims

PHP shall notify a Provider of any deficiencies in a submitted claim not more than:

A. thirty (30) days for a claim that is filed electronically; or
B. forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a Clean Claim. If PHP does not follow this procedure, then the submitted claim will be treated as a Clean Claim.

PHP shall pay or deny each Clean Claim not more than:

A. thirty (30) days after we receive a Clean Claim if the Provider filed it electronically; or
B. forty-five (45) days after we receive a Clean Claim if the Provider filed it on paper.

If the Contract is provided under an employee welfare benefit plan within the meaning of § 3(1) of ERISA, then PHP shall pay or deny each Clean Claim in accordance with § 503 of ERISA and its interpretive regulations.

Medicare Eligibility

When a Member who is eligible to enroll in Medicare Part B and, if so enrolled, Medicare Part B would be the Primary Plan to this Policy, (see COB Order of Benefit Determination Rules below for exceptions in which this Policy would be the Primary Plan) the Member shall be deemed to be enrolled in Medicare Part B for purposes of these COB provisions, whether or not the Member actually enrolled in Medicare Part B. The Member shall be deemed to have received the amount they would have received under Medicare Part B as if they were actually enrolled in Medicare Part B, and benefits under this Policy, as the Secondary Plan, shall be reduced or denied accordingly. This provision shall be administered consistent with the Social Security Act of 1965 and applicable Ohio insurance laws and regulations. **You should sign up for Medicare as soon as possible to avoid large out of pocket costs.**

Coordination of This Contract's Benefits with Other Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care Coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable Expense.

Definitions

A Plan is any of the following that provides benefits or services for medical or Dental Care or treatment. If separate contracts are used to provide coordinated Coverage for Members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

A. Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts, and Medicare or any other federal governmental plan, as permitted by law.

B. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care Coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is Covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not Covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered person is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

A. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
B. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
C. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
D. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
E. The amount of any benefit reduction by the Primary Plan because a Covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, Precertification of admissions, and preferred provider arrangements.

Closed Panel Plan is a Plan that provides health care benefits to Covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or Referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is Covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
B. 1) Except as provided in Paragraph (2), a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
   2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
D. Each Plan determines its order of benefits using the first of the following rules that apply:
   1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for

example as an employee, Member, policyholder, Subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, Subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
   (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
      (3) However, if one spouse's Plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that Plan.
   (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      (4) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The Plan covering the custodial parent;
         - The Plan covering the spouse of the custodial parent;
         - The Plan covering the non-custodial parent; and then
         - The Plan covering the spouse of the non-custodial parent.
   (c) For a dependent child Covered under more than one Plan of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

5) Longer or shorter length of coverage. The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. PHP may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans Covering the person claiming benefits. PHP need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give PHP any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, PHP may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. PHP will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by PHP is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Follow the steps listed in the “Grievance” section of this Certificate. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at *http://insurance.ohio.gov*

Timely Information

You agree to provide to us all information relating to duplicate Coverage for which there may be COB:

A. in a timely manner; but
B. no later than one year after the effective date of the other Coverage.

Our Rights to Reimbursement, Recovery, and Subrogation

Benefits are not payable for Injury(ies) or Sickness(es) to you or your Dependent(s) to which a third party(ies) may have caused or contributed. However, PHP may elect, in its sole discretion, to advance payments for medical expenses incurred for any Injury(ies) or Sickness(es) to you or your Dependent(s) to which a third party(ies) may have caused or contributed.

A. If you obtain a Recovery from a Recovery Source for a Sickness or Injury or other condition for which you have received Health Services, then we will not Cover such Health Services to the extent of such recovery.
B. However, if we advanced payment for such Health Services:
   1) you shall reimburse us immediately from a collected Recovery for 100% of the Health Services we Covered without a reduction for:
      (a) your attorney fees; and
      (b) other costs incurred in obtaining or collecting the Recovery;
      regardless of whether or not that collected amount fully compensates you;
   2) for a Recovery not yet collected, you grant to us a first priority lien against such Recovery for 100% of the Health Services we Covered without a reduction for:
      (a) your attorney fees; and
      (b) other costs incurred in obtaining and eventually collecting the Recovery;
      regardless of whether or not the Recovery fully compensates you. We may give notice of such lien to the Recovery Source. The "common fund doctrine", "made whole" rule, or similar common law doctrines do not reduce or affect the Plan's subrogation and reimbursement rights.

      You also assign to us any benefits that you may have under any car insurance policy or other sources in order to enforce our rights under this section;
   3) we are subrogated to your rights to seek a Recovery from a Recovery Source under any legal or equitable theory that you could assert against that Recovery Source. At our option, we may bring a lawsuit against the Recovery Source in your name or take, in our sole discretion, such other necessary and appropriate action to preserve or enforce our rights under this section; and
   4) you grant to us a first priority lien against any Recovery we obtain under this section, whether or not you are fully compensated by the Recovery, to the extent of:
      (a) 100% of the Covered Health Services; and
      (b) our reasonable costs, including attorney's fees, of pursuing and collecting the Recovery.

PHP's rights of subrogation and reimbursement described above shall be modified to comply with the terms of this paragraph in the event that less than the full value of the third party action is recovered due to comparative negligence on your part, diminishment of the recovery due to the apportionment of liability among and recovery on judgment against multiple co-defendants, or by reason of the collectability of the full value of the claim for injury, death, or loss to you resulting from limited liability insurance or any other cause. If less than the full value of the third-party action is recovered due to the reasons mentioned in the preceding sentence, PHP's claim shall be reduced in the same proportion as your interest is reduced. Both PHP and the Member shall have the right to seek a declaratory judgment pursuant to Ohio Revised Code Section 2721 if there is a dispute over the distribution of the recovery in a tort action.

All Recoveries will be deemed as compensation for Covered Health Services regardless of how the Member or the Member's legal representative defines it.

We shall be responsible only for those legal fees and expenses relative to your Recovery to which we agree in writing.

If the Sick or Injured Member is a minor, any Recovery shall be subject to this section to the extent permitted by

applicable law, regardless of whether such Member's parent, trustee, guardian, or other representative has access to or control of the Recovery.

The Member agrees that acceptance of Covered Health Services is constructive notice of this section in its entirety and constitutes full consent to it.

Your Full Cooperation Required

In order to protect our rights under this section, you shall:

A. hold any collected Recovery in trust for our benefit;
B. notify us of a claim or suit against a Recovery Source within thirty (30) days of the action and of a proposed settlement at least thirty (30) days before it is entered. You shall not, without our written approval, accept any settlement that does not fully compensate or reimburse us. If you fail to notify us in accordance with this section, we shall not be obligated to cover the Health Services that provide a basis for the claim, suit or settlement;
C. execute and deliver such documents as we may reasonably request including, but not limited to, documents to protect and perfect our liens, to affect an assignment of benefits, and to release records;
D. provide us, or any party acting on our behalf, any facts we need to subrogate the claim in a timely manner, but not more than one year after our initial request for information or you will be responsible for any incurred claims;
E. provide such other cooperation and information as we may reasonably request including, but not limited to, responding to requests for information about an accident, Sickness or injuries and making court appearances; and
F. not prejudice our rights.

Who May File

You or your Designated Representative may file:

A. a Grievance;
B. an Appeal; or
C. a request for an External Appeal.

In each of these review processes, your notice to us is considered to be filed on the date we first receive it orally or in writing.

Neither you nor your Designated Representative will be subject to retaliation from us for exercising your rights to any of the review processes described in this section. Also, we may not take any action against a Provider solely on the basis that the Provider represents you in any of the review processes described in this section.

Grievance Procedure

A Grievance may be directed to us orally or in writing at the address, toll free number, or e-mail address set forth below in "Contact Us." In your Grievance, you should express your concerns in detail and provide copies of any supporting documents. We must receive your request to initiate the Grievance process within one hundred eighty (180) days from the date we provide you an initial notice of denial. We will acknowledge your Grievance, orally or in writing, within three (3) business days of our receipt of it. We will maintain records reflecting any Grievance that we receive and will document any action taken.

We will conduct a thorough investigation of the facts of your Grievance and make a decision regarding it. We may consult with other PHP employees or Providers before we make a decision.

We will make our decision regarding your Grievance as soon as possible, but no later than:

A. seven (7) business days after the date your Grievance was filed, for a Pre-service Grievance; and
B. the earlier of twenty (20) business days or thirty (30) days after the date your Grievance was filed, for a Post-service Grievance.

If we are not able to make a decision by the applicable deadline due to reasons beyond our control, we will:

A. notify you in writing of the reason for the delay before the applicable deadline; and
B. notify you of our written decision within the earlier of ten (10) business days or fifteen (15) days.

If the delay in our decision is because we need more information from you about your claim, you will have forty-five (45) days from the date we send you our notice to provide us such information.

In that case, our extended decision period will not begin to run again until:

A. we receive such information from you; or
B. the end of the forty-five (45) day period, whichever is earlier.

If you are not satisfied with our decision regarding your Grievance, you have the right to file an Appeal with us as set forth below.

Content of Grievance Decision

Any notice of an adverse determination on your Claim will:

A. state the specific reason or reasons for denial of your Grievance;
B. reference the specific Certificate provision(s) on which the determination is based;
C. describe the Certificate review procedures and applicable time limits (including a statement of your right to bring a civil action under ERISA, if This Plan is governed by ERISA);
D. disclose any internal rule, guideline, protocol, or other similar criterion that we relied upon when making the determination of your Grievance (or tell you that the information will be provided free of charge); and

E. explain, in a manner that applies the terms of the Certificate to your medical circumstances, the scientific or clinical judgment for any determination that was based on Medical Necessity or the experimental nature of a treatment (or tell you that the explanation will be provided free of charge).

Appeal Procedure

If you are not satisfied with our decision regarding your Grievance, you have the right to submit an Appeal to us within one hundred eighty (180) days of our decision regarding your Grievance. The Appeal may be expressed orally or in writing. We will acknowledge your Appeal, orally or in writing, within three (3) business days of our receipt of it. We will maintain records reflecting any Appeal that we receive and will document any action taken.

Our Appeal Committee (Committee) will resolve the Appeal. The Committee shall be comprised of qualified individuals who were not involved in the initial Adverse Benefit Determination or resolution of the Grievance or involved in the matters giving rise to it. If the Appeal concerns health care procedures, treatments, or services that have been proposed, refused, or delivered, the Committee shall include one or more individuals who:

A. have knowledge of the Health Services at issue;
B. are in the same licensed profession as the Provider who proposed, refused or delivered the Health Service at issue; and
C. do not have a direct business relationship with you or with the Provider who recommended the Health Service at issue.

You or your Designated Representative may:

A. appear in person before the Committee; or
B. communicate with the Committee through other appropriate means, if unable to attend in person.

You will have access free of charge to copies of all relevant documents, records, and other information, as described by applicable U.S. Department of Labor regulations.

To support your Appeal, you should submit to the Committee any written issues; arguments; comments; testimony; or other documented evidence. Sufficiently prior to the decision, you will also be provided any new or additional evidence and/or rationale considered, relied upon or generated in connection with the claim. You will be provided a reasonable period to review and respond to such new evidence or rationale. The Committee shall review all findings and pertinent documents, including any aspects of clinical care, whether or not we have considered them previously. The Committee will also avoid conflict of interest and ensure that the claim and Appeal decisions are decided in an impartial and independent manner.

The Committee will not afford any special deference to the original denial of your Grievance. In no event shall your claim that was previously denied under the terms of the Contract and upheld by an Appeals ruling be reconsidered by the Committee for review.

The Committee's decision regarding your Appeal will be made as soon as possible and with regard to the clinical urgency of the Appeal, but not later than fifteen (15) days after the Appeal was filed. We will notify you in writing of the Committee's decision within five (5) business days after it is decided.

Content of Decision on Appeal

Any notice of an Adverse Benefit Determination on your Appeal will:

A. include the date of service, Provider (if applicable), claim amount, diagnosis code, treatment code and their meaning, the denial code and their meaning, a description of the standard (if any) that was used in denying the claim;
B. state the specific reason or reasons for the determination;
C. reference the specific Certificate provisions upon which the determination is based;
D. state that you are entitled to access free of charge to all documents records and other information relevant to your Appeal;
E. describe your right to bring a civil suit under federal law;

F. disclose any internal rule, standard, guideline, protocol or similar criterion that was relied upon in making the adverse determination (or a statement that such information will be provided free of charge);
G. explain the scientific or clinical judgment for a benefit determination that was based upon a Medical Necessity or experimental treatment, or other similar exclusion or limit by applying the terms of the Certificate to your circumstances (or state that this explanation will be provided free of charge);
H. state that you or your Designated Representative may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency; and
I. include a discussion of the decision for the notice of Final Internal Adverse Benefit Determination.

Urgent Care Claim Procedure

If your claim was processed as an Urgent Care Claim and the claim is denied, you may make a request for an expedited review of the determination orally or in writing. All necessary information regarding the review may be transmitted by telephone, facsimile, or other available similarly expeditious method. You must be notified of the determination by any of the methods mentioned above as soon as possible, taking into account the medical urgency, but no later than twenty-four (24) hours after your request for review is received, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are Covered or payable. You may be asked to explain the medical urgency that applies to your request for review.

Concurrent Care Claim Procedure

If we reduce or terminate a concurrent care plan or course of treatment (other than by amending the Certificate) before the end of the period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to file a Grievance and Appeal of the decision before it becomes effective.

We will notify you of our decision to extend a particular course of treatment within twenty-four (24) hours of our receipt of your request if:

A. the request is received within at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments; and
B. failure to extend the time period or course of treatment could seriously jeopardize your life, health, or ability to regain maximum function; or
C. failure to extend the time period or course of treatment, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot otherwise be adequately managed.

External Review

You may make a request for an external review of an Adverse Benefit Determination. All requests for external review shall be made in writing, including by electronic means, by you to PHP within one hundred eighty (180) days of the date of the Final Adverse Benefit Determination. However, in the case of an expedited external review, the review may be requested orally. An Adverse Benefit Determination shall be eligible for internal Appeal or external review, regardless of the cost of the requested health care service related to the Adverse Benefit Determination. Also, if you are a Medicare recipient and have a right to an external review under Medicare (42 U.S.C. 1395 *et seq.,* as amended from time to time), there is no right to request an external review with PHP.

If we deny a request for an external review on the basis that the Adverse Benefit Determination is not eligible for an external review, we shall notify you in writing of both of the following:

A. The reason for the denial;
B. That the denial may be Appealed to the superintendent.

If we deny a request for external review on the basis that the Adverse Benefit Determination is not eligible for an external review, the Covered person may Appeal the denial to the superintendent of insurance.

Regardless of a determination made by PHP, the superintendent of insurance may determine that a request is

eligible for external review. The superintendent's determination shall be made in accordance with the terms of your benefit plan and shall be subject to all applicable provisions of ORC 3922.05.

If an external review of an Adverse Benefit Determination is granted, the superintendent, according to any rules, policies, or procedures adopted by the superintendent will assign an Independent Review Organization from the list of organizations maintained by the superintendent under section 3922.13 of the Revised Code to conduct the external review. For external review of an Adverse Benefit Determination that did not involve a medical judgment or any medical information, we will allow for an external review by the superintendent of insurance. For an adverse benefit decision in which Emergency medical services have determined to be not Medically Necessary or appropriate after an external review, we shall afford you the opportunity for an external review by the superintendent of insurance.

In the case of a standard external review, within five days after the receipt of a request for an external review that is complete and valid, PHP shall provide to the assigned Independent Review Organization all documents and information considered in making the Adverse Benefit Determination. The Independent Review Organization will provide a decision within thirty (30) calendar days of receipt of the request for Appeal, including written notification of the Appeal decision to the patient, attending physician, or other ordering Provider or facility rendering service.

You may make a request for an expedited external review, except as detailed below:

A. After an Adverse Benefit Determination, if both of the following apply:
   1) The Member's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Member, or would jeopardize the Members' ability to regain maximum function, if treated after the time frame of an expedited internal Appeal;
   2) The Member has filed a request for an expedited internal Appeal.
B. After a Final Adverse Benefit Determination, if either of the following apply:
   1) The Member's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Member, or would jeopardize the Member's ability to regain maximum function, if treated after the time frame of a standard external review;
   2) The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the Member received Emergency services, but has not yet been discharged from a facility.

Immediately upon receipt of a request for an expedited external review, PHP shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review as detailed above. PHP shall immediately notify the Covered person of its determination in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance. If a request for an expedited review is complete and eligible, PHP shall immediately provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination in question to the assigned Independent Review Organization electronically, or by facsimile or other available expeditious method. PHP shall communicate the Independent Review Organization's decision to the originator of the Appeal within seventy-two (72) hours from the initiation of the Appeal to PHP. Written confirmation of the expedited Appeal determination will be provided within seventy-two (72) hours to the patient, and his or her designated representative, if applicable, and the attending physician or other ordering Provider or facility rendering service.

You may request an external review of an Adverse Benefit Determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the Covered person's benefit plan. To be eligible for an external review under this section, your treating physician shall certify that one of the following situations is applicable:

A. Standard health care services have not been effective in improving the condition of the Covered person.
B. Standard health care services are not medically appropriate for the Covered person.

C. There is no available standard health care service Covered by the health plan issuer that is more beneficial than the requested health care service.

For external review that involves an experimental or investigational treatment, you may request orally or by electronic means an expedited review if the person's treating physician certifies that the requested health care service in question would be significantly less effective if not promptly initiated. Immediately upon receipt of a request for an expedited external review, PHP shall determine if the request is complete under any associated rules, policies, or procedures adopted by the superintendent of insurance and eligible for expedited external review as detailed above. PHP shall immediately notify the Covered person of its determination in accordance with any associated rules adopted by the superintendent of insurance. PHP shall provide to the assigned Independent Review Organization all documents and information considered in making the Adverse Benefit Determination. Within thirty (30) days after the date of receipt by PHP of a request for a standard external review, or within seventy-two (72) hours of receipt by PHP of a request for an expedited external review, the assigned Independent Review Organization shall provide written notice of its decision to uphold or reverse the Adverse Benefit Determination to the covered person, PHP, and the superintendent of insurance.

The superintendent of insurance shall establish and maintain a system for receiving and reviewing requests for external review for Adverse Benefit Determinations where the determination by PHP was based on a contractual issue and did not involve a medical judgment or a determination based on any medical information, except for Emergency services, as specified in section 3922.05(C) of the Revised Code. PHP shall submit a request for external review pursuant to division (B) or (C) of section 3922.05 of the Revised Code to the superintendent, in accordance with any associated rules, policies, or procedures adopted by the superintendent of insurance. On receipt of a request from PHP, the superintendent shall consider whether the health care service is a service Covered under the terms of the Covered person's Certificate, except that the superintendent shall not conduct a review under this section unless the Covered person has exhausted PHP's internal Appeal process, pursuant to sections 3922.03 and 3922.04 of the Revised Code. PHP and covered person shall provide the superintendent with any information required by the superintendent that is in their possession and is germane to the review. Unless the superintendent is not able to do so because making the determination requires a medical judgment or a determination based on medical information, the superintendent shall determine whether the health care service at issue is a service covered under the terms of the Covered person's Certificate. The superintendent shall notify the Covered person and PHP of the superintendent's determination. If the superintendent notifies PHP that making the determination requires a medical judgment or a determination based on medical information, PHP shall initiate an external review as detailed above.

You are required to cooperate with the IRO by providing or authorizing the release of any applicable medical information that we have not already provided. At all times during the External Appeal process, you are permitted to submit any relevant information to the IRO.

If your External Appeal involves a Sickness, disease, condition, Injury or disability that would seriously jeopardize your life or health or ability to reach and maintain maximum function, the IRO must make its determination and notify you of such determination within seventy-two (72) hours after the external Grievance is filed.

Upon your request, the IRO shall provide you all information reasonably necessary to enable you to understand:

A. the effect of the determination on you; and
B. the manner in which we may be expected to respond to the determination.

The IRO's decision in an External Appeal is binding on us, but you may have other legal remedies.

Contact Us

Questions regarding your policy or Coverage should be directed to:

Physicians Health Plan of Northern Indiana, Inc.
1700 Magnavox Way, Suite 201

Fort Wayne, IN 46804
(260) 432-6690
(800) 982-6257
(260) 432-0493 fax
custsvc@phpni.com (e-mail)

Ohio Department of Insurance

If you:

A. need the assistance of the governmental agency that regulates insurance; or
B. have a complaint you have been unable to resolve with your insurer;

you may contact the Department of Insurance by mail, telephone or email:

Ohio Department of Insurance
Consumer Services Division
Ohio Department of Insurance
50 W Town Street, Suite 300
Columbus, OH 43215

Consumer Hotline: (800) 686-1526

Complaints can be filed electronically at www.insurance.ohio.gov

Ohio Medical Malpractice Actions

The review procedures described in this section do not govern any issue covered in whole or in part by Ohio Medical Malpractice Actions (ORC 2305.113). All such claims must be brought in accordance with applicable Ohio law.

Conditions for Termination of All PHP's Group Coverage

As long as we act uniformly without regard to the claims experience of any Group or any health factor of any Member or potential Member under a PHP Contract, we may, at our discretion, terminate the Contract if we want to stop offering:

A. the type of Coverage provided by the Contract to small or large Employer groups (whichever size applies to the Group) in this state; or
B. all contracts to small or large Employer groups (whichever size applies to the Group) in this state.

If we propose to terminate the Contract because of A., we will give the Group and you at least ninety (90) days written notice of termination. If we propose to terminate the Contract because of B., we will give the Group and you at least one hundred eighty (180) days written notice of termination.

Conditions for Termination of a Member's Coverage under the Contract

A Member's Coverage shall automatically end on the earliest of the dates set forth below:

A. The date the whole Contract ends. The Group is responsible for notifying you of the ending of the Contract.
B. When the Subscriber is no longer an employee of the Group.
C. The last day for which the Subscriber's contribution toward the Premium has been paid, if the Subscriber is required to contribute.
D. The date stated in our written notice to a Member that all Coverage under the Contract ended or will end for that Member because the Member misrepresented material information such as:
   1) information relating to another person's eligibility for Coverage or status as a Dependent; or
   2) information relating to a Subscriber's or Dependent's utilization of, or attempts to utilize, Health Services.
E. The date stated in our written notice to a Member that all Coverage under the Contract ended or will end for that Member because the Member:
   1) permitted the use of his/her I.D. card by any unauthorized person;
   2) used another person's card; or
   3) committed any other act of fraud under the Contract.
F. The date the Group receives written notice from the Subscriber requesting termination of Coverage or the date requested by the Subscriber in such notice, if later.
G. The date the Subscriber is retired or pensioned, unless retired or pensioned persons are approved by PHP to be Covered under the Contract.
H. The date specified by us, after at least thirty-one (31) days prior written notice to the Subscriber that all Coverage under the Contract will end. This notice may be issued if a Member fails to:
   1) follow a prescribed course of treatment;
   2) cooperate with us in our administration of the Coordination of Benefits section of the Contract; or
   3) furnish us with information needed to comply with governmental mandatory reporting requirements.
I. The date specified in a written notice from the Group on which the Member ceases to be eligible for Coverage if:
   1) we receive such notice within sixty (60) days of the date specified in the notice; and
   2) no paid claims have been incurred on behalf of the Subscriber or any Enrolled Dependents between the date specified in the notice and the date for which we receive the notice.
J. When the Subscriber no longer meets the definition of Actively at Work as set forth later in this Certificate.
K. The date an individual ceases to be an Eligible Person or a Dependent as determined by PHP (in the event of a conflict between Group and PHP regarding eligibility, PHP's determination controls and is final and binding).

In any event, an Enrolled Dependent's Coverage shall end on the date the Subscriber's Coverage ends.

If any Member misrepresented or knowingly provided PHP with false material information relating to a

Subscriber's or any Dependent's health status, PHP reserves the right to retroactively modify, to the appropriate date, the schedule of rates for Premium to incorporate the proper information as set forth in the Contract.

Our notice to the Subscriber shall be deemed as:

A. notice to the Subscriber's Enrolled Dependents;
B. sufficient if mailed to the Subscriber's address as it appears in our records; and
C. delivered when deposited in the United States mail with first class postage prepaid.

Health Services rendered after the date of termination are not Covered, even if the medical condition arose before Coverage ended. The Subscriber shall reimburse PHP for any payment we made for Health Services provided to the Subscriber or to an Enrolled Dependent when such person was not Covered. Termination of the Contract shall not prejudice any claims for Health Services that were rendered before the Contract ended.

Under certain circumstances, you may be eligible to continue Coverage or you may be entitled to conversion Coverage.

Special Rules for Military Service

A Subscriber whose employment ends due to military service may have certain rights to Coverage. Such will be entitled to Coverage as required by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time. Contact the Group to determine your rights.

A Subscriber may continue the Coverage under the Contract for a period of eighteen (18) months after the date on which the Coverage would otherwise terminate because the reservist is called or ordered to active duty. A Subscriber may extend the eighteen (18) month period of continuation of coverage to a thirty-six (36) month period of continuation of coverage, if any of the following occurs during the eighteen (18) month period:

A. The death of the reservist;
B. The divorce or separation of a reservist from the reservist's spouse;
C. The cessation of dependency of a child pursuant to the terms of the contract.

The thirty-six (36) month period of continuation of coverage is deemed to begin on the date on which the Coverage would otherwise terminate because the reservist is called or ordered to active duty. The employer may begin the thirty-six (36) month period on the date of any occurrence described above.

Special Rules under the Family and Medical Leave Act

Special rules apply if the Group is subject to the Family and Medical Leave Act of 1993, as amended (the Act). Contact the Group to determine your rights.

A Subscriber will be deemed to be Actively at Work if he or she is on a leave under the Act. Coverage under the Contract will not end while Subscriber is on a leave under the Act provided all required Premium is paid during the leave.

A reduction in hours caused by a leave under the Act is not a qualifying event that gives rise to a right to choose COBRA continuation Coverage. This is because such a leave does not result in a loss of Coverage.

Coverage will again become effective as of the date the Subscriber returns to work if:

A. Coverage ends during a leave under the Act; and
B. the Subscriber returns to work after the leave.

Reinstatement

Unless you have been terminated for reasons stated in D. and/or E. above, your terminated Coverage may be reinstated:

A. if the Group pays any outstanding Premium, including the current Contract Month's Premium, in full to

us within sixty (60) days of termination; and

B. if you have not exercised this reinstatement right during the preceding twelve (12) months.

Extended Coverage for Disabled Children

Coverage for an Enrolled Dependent may continue beyond the limiting age if:

A. at the time of the limiting age, the Enrolled Dependent is incapable of self-sustaining employment due to intellectual disability, Behavioral Health and Mental Health disabilities or physical disabilities;
B. the Enrolled Dependent is primarily dependent upon the Subscriber for support and maintenance; and
C. proof of such incapacity and dependency is furnished to us by a Par Provider within one hundred twenty (120) days of reaching the limiting age.

This extended Coverage will continue so long as the Enrolled Dependent remains so incapacitated and dependent, unless Coverage is otherwise ended by the terms of the Contract.

We may require proof from a Par Provider that is satisfactory to us of the Enrolled Dependent's continued incapacity and dependency.

Continued Inpatient Hospital Benefits

We will continue inpatient Hospital benefits if:

A. we terminate the Contract; and
B. you are Confined for a medical or surgical condition on the date the Contract ends;
C. In the event of PHP's insolvency or discontinuance of operations.

The continuation of coverage shall terminate at the earliest occurrence of any of the following:

A. the Member's discharge from the Hospital;
B. the determination by the Member's attending physician that inpatient care is no longer medically indicated for the Member;
C. the Member's reaching the limit for contractual benefits.
D. the date you are covered under another coverage plan if that plan covers inpatient medical or surgical benefits.
E. sixty (60) days after the date the Contract ends.
F. the date specified in writing by the Group. Such date shall be at least fifteen (15) days after the date written notice of termination is:
   1) placed in the United States mail; or
   2) sent by facsimile transmission.
G. the last day the required Contract Charge has been paid, if the grace period expires and the Group has not made the required payment.
H. the date we specify, if you knowingly provide false information to us.
I. the date we specify, if you fail to comply with the Contract's requirements.
J. the last day the required Premium has been paid, if the grace period expires and the Subscriber has not made the required payment.
K. the date the Subscriber terminates Coverage for the Subscriber and any Enrolled Dependents.

This section does not apply if the Contract ends due to the receivership of PHP.

Continuation Coverage under COBRA

The following is only a summary of COBRA and how it may apply to you. The Group is responsible for providing you with complete information about COBRA. COBRA Coverage shall apply only if the Group is subject to COBRA. Contact the Group's Plan Administrator to determine if you are entitled to COBRA.

If you have been receiving COBRA Coverage under your Group's prior plan, your COBRA Coverage may continue under the Contract until the earlier of:

A. the date it would have ended under the prior plan; or
B. the date it would end in accordance with the events in Termination Events for COBRA.

We are not required to provide you with COBRA Coverage if the Group or its Plan Administrator fails to perform its responsibilities under federal law. These responsibilities include, but are not limited to:

A. timely notifying you of the right to elect COBRA; and
B. timely notifying us of your COBRA election.

PHP is not the Group's designated Plan Administrator. We do not assume the Group's COBRA responsibilities under federal law.

Qualifying Events for COBRA

You are entitled to COBRA Coverage if your regular Coverage ended due to one of the following:

A. termination of the Subscriber from employment (other than for gross misconduct), or reduction of the Subscriber's work hours;
B. death of the Subscriber;
C. divorce or legal separation of the Subscriber;
D. loss of eligibility by a child who is an Enrolled Dependent;
E. entitlement of the Subscriber to Medicare benefits;
F. the bankruptcy filing by the Group under Title XI of the United States Code:
    1) with respect to a retired Subscriber and his or her Enrolled Dependents; and
    2) if there is a substantial elimination of Coverage within one year before or after the date the bankruptcy was filed.

The COBRA Coverage period begins to run from the date of the loss of regular coverage, even if the qualifying event occurs some time earlier.

Notification Requirements and Election Period for COBRA

You must notify the Group's Plan Administrator within 60 days of:

A. a divorce;
B. a legal separation; or
C. the loss of eligibility as an Enrolled Dependent.

You have sixty (60) days to elect COBRA Coverage. The sixty (60) day period ends the later of:

A. sixty (60) days after the qualifying event; or
B. sixty (60) days after you receive notice from the Plan Administrator of your right to elect COBRA.

Your failure to timely notify the Group's Plan Administrator will eliminate the right to elect COBRA Coverage.

You must pay the initial COBRA Premium to the Plan Administrator within forty-five (45) days after electing COBRA. Coverage will be retroactively reinstated when we receive notice from the Group that payment has been received.

COBRA Coverage will be the same as the regular Coverage you were receiving at the time of the qualifying event. You cannot reduce or change your COBRA Coverage unless similarly situated active employees of the Group have the opportunity to do so.

Termination Events for COBRA

COBRA Coverage will end on the earliest of the following dates.

A. Eighteen (18) months from the date of loss of regular Coverage.
B. Thirty-six (36) months from the date of loss of regular Coverage for an Enrolled Dependent whose regular Coverage ended because of:
    1) the death of the Subscriber;
    2) divorce or legal separation;

3) the loss of eligibility by an Enrolled Dependent who is a child; or
4) the entitlement of the Subscriber to Medicare benefits.

C. The date you fail to pay the COBRA Premium. COBRA Premium is due:
1) Forty-five (45) days from the date you elect COBRA Coverage;
2) the first day of each month thereafter with a thirty-one (31) day grace period.

D. The date you become covered, after the date you elect COBRA, under any other group health plan. If the other group health plan contains pre-existing limitations or exclusions, your COBRA Coverage shall end on the date such limitations or exclusions end. The other group health plan shall be primary for all Health Services except those that are subject to the pre-existing limitations or exclusions.

E. The date the Member becomes entitled to Medicare after electing COBRA Coverage. This provision shall not apply if the Member's regular Coverage ended because of bankruptcy filing of the Group.

F. The date the entire Contract ends. If a new group health plan is offered, you may have COBRA rights under that plan.

G. The date COBRA Coverage would otherwise end under the Contract.

Extended COBRA

COBRA Coverage may be extended as described below.

A. If a second qualifying event occurs less than eighteen (18) months after the termination of the Subscriber from employment (other than for gross misconduct), or reduction of the Subscriber's work hours, COBRA Coverage may be extended for an Enrolled Dependent up to thirty-six (36) months after the date of loss of regular Coverage.

The following events are not considered a second qualifying event:
1) entitlement of the Subscriber to Medicare benefits, unless it would have caused a loss in regular Coverage, had the first qualifying event not occurred; and
2) bankruptcy filing of the Group as set forth in Qualifying Events for COBRA.

B. COBRA Coverage may be extended up to twenty-nine (29) months if a Member:
1) is determined by the Social Security Administration to be disabled prior to or within sixty (60) days from the qualifying event; and
2) notifies the Group within the first eighteen (18) months of COBRA Coverage and within sixty (60) days from the latest of:
(a) the date of disability determination;
(b) the date of the qualifying event;
(c) the date COBRA is lost; or
(d) the date you were informed by the Group of your obligation to notify them.

You must provide notice to the Group within thirty (30) days from the date it is determined that you are no longer disabled. The extension will end on the first day of the month that is more than thirty (30) days after the date it is determined that you are no longer disabled.

C. If a Subscriber:
1) becomes entitled to Medicare; and
2) later experiences termination of employment (other than for gross misconduct), or reduction of work hours;

COBRA Coverage for an Enrolled Dependent will be the longer of:
1) thirty-six (36) months after the date of loss of regular Coverage due to the Subscriber becoming entitled to Medicare; or
2) eighteen (18) months from the date of loss of regular Coverage due to the Subscriber's employment being terminated (other than for gross misconduct), or reduction of work hours.

State Continuation Coverage

In this section, Eligible Dependents under State Continuation means the certificate holder's spouse, and Eligible Dependent children of the certificate holder or the certificate holder's spouse.

If the Subscriber's Coverage stops due to an involuntary termination of employment, and the termination of

employment is not a result of any gross misconduct on the part of the Subscriber, the Subscriber may be eligible to continue Group Coverage. The Subscriber is eligible for continuation of Group benefits when, at the time of termination, the Subscriber meets all of the following criteria:

- Continuously Covered by the Contract or a similar contract for the three (3) month period immediately prior to termination of employment; not eligible for nor covered by Medicare; and not eligible for any other Group medical coverage.
- If the Subscriber is eligible for continuation of Group benefits, Coverage for the Subscriber and his/her Dependents may continue for up to twelve (12) months following termination of employment. This continuation of coverage applies only to health coverage and is contingent upon the Subscriber's payment of the required Premium.

Entire Contract

The Contract, the Certificate, the attachments, the declarations page, and any Amendments or Exhibits, make up the entire Contract between the Group, you and us.

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Contract or be used in defense of a legal action unless it is contained in a written application or Enrollment Form.

Limitation of Action

Requests for reimbursement are subject to the provisions of the Contract. Otherwise, no legal proceeding or action may be brought to recover on the Contract prior to full and complete compliance with the procedures set forth in the Grievances section of the Contract. Also, no such proceeding or action may be brought unless brought within three years from the date the cause of action first arose.

The Member's damages shall be limited to recovery of actual benefits due under the terms of the Contract. The Member waives any right to recover any additional amounts or damages including, but not limited to, punitive and/or exemplary damages.

Time Limit on Certain Defenses

No misstatement, except a fraudulent misstatement made by the Group in the written application or the Subscriber in the Enrollment Form, shall be used to void the Contract after it has been in force for a period of two years.

Amendments and Alterations

No change will be made to the Contract unless made by an Amendment signed by an executive officer of PHP. Amendments to the Contract are effective as specified in the Amendment.

No agent has authority to change the Contract or to waive any of its provisions. No person has authority to make oral changes to the Contract.

Relationship between Parties

The relationships between PHP and Par Providers are ***solely*** contractual relationships between a payor (PHP) and independent contractors (Par Providers). The pharmacy or Mail Order Drug Provider, as the case may be, is ***solely*** responsible for the pharmacy services provided to any Member. Likewise, PHP is an independent contractor providing Coverage for Health Services to Groups on a contractual basis. Non-Par Providers have no contractual relationship with PHP, nor are they independent contractors of PHP.

Neither the Providers nor the Groups are considered agents or employees of PHP. We and our employees are not employees or agents of Providers or the Group.

The relationship between a Provider and any Member is that of Provider and patient. The Provider is ***solely*** responsible for the services provided to any Member. We are not responsible for the Health Services or other care of any kind you receive from Providers or any other persons or entities. The Contract does not give you or any other person any right, claim or cause of action of any kind against us based on the actions or omissions of any Provider, entity or other person of health care, services or supplies.

The relationship between the Group and any Member is that of employer and employee, Enrolled Dependent, or other Coverage classification as defined in the Contract.

The Group is ***solely*** responsible for:

A. determining enrollment and Coverage classification changes;
B. termination of Members' Coverage; and
C. paying the Contract Charge to us on time.

Limitations on Selection of Par Providers for In-Network Benefits

If we determine that you are using Health Services of Par Providers, including pharmacy services, in a harmful or abusive quantity, manner or frequency, we may limit your selection of Par Providers or Par Pharmacies for In-Network Benefits Coverage. In this case, you may be required to select a single Par Doctor and a single Par Hospital with which that Par Doctor is affiliated for all future Health Services Covered as In-Network Benefits. Or, you may be required to select a single Par Pharmacy for the provision and coordination of all future pharmacy services.

If you fail to make the required selection within thirty-one (31) days of our written notice of the need to do so, we will make the selection for you and notify you in writing. All Health Services, including pharmacy services, following this selection or appointment of a single Par Doctor or Par Pharmacy must be provided by that Par Doctor (or through his or her written Referral) or that Par Pharmacy for Coverage under In-Network Benefits. If you have a medical condition that requires or could benefit from special services, we may require that you receive Health Services through a single Par Provider for In-Network Benefits Coverage.

Some Health Services must be provided in a facility that we designate for In-Network Benefits Coverage. This applies even though there may be other Par Providers that provide the same or similar services.

Services by a Provider that PHP has determined uses abusive or fraudulent services and/or billing practices shall be excluded, unless the Provider can demonstrate that the services were Medically Necessary and billed in accordance with industry standards.

Second Opinion Policy

A second opinion may be required at PHP's discretion prior to the scheduling of Certain Health Services. PHP will advise you if a proposed Health Service is subject to the second opinion policy. If so, you must consult with a second Par Doctor prior to scheduling the service.

You must:
A. contact us to obtain a list of Par Doctors who are authorized to render a second opinion; and
B. arrange a consultation with the second Par Doctor. The second Doctor will not be affiliated with the first Doctor.

You must obtain the second opinion within thirty-one (31) days of the first opinion or as soon thereafter as is reasonably possible. Second opinions arranged through PHP as described above are provided at no cost to you.

A second opinion may also be obtained at the request of a Member, subject to separate benefit restrictions and/or Copays/Coinsurance described elsewhere in the Contract.

Wellness and Cost Containment Programs

We may implement wellness or cost containment programs for Members. Such programs may Cover services and supplies that would not otherwise be Covered. Such programs are at our sole discretion and may be discontinued at any time without prior approval from other parties.

Confidentiality of Medical Information

By accepting Coverage, you authorize and direct any Provider that has attended, examined, or treated you to furnish us any and all related information and records. Such must be provided to us at any reasonable time,

upon our request.

We and our designees have the right to any and all records concerning Health Services as necessary:
A. to implement and administer the terms of the Contract;
B. for appropriate medical review or other quality assessment; or
C. for purposes of health care research.

Any information we obtain that pertains to your diagnosis, treatment or health is confidential. We shall not disclose such information to any person except:
A. to fulfill our obligations as described above; or
B. as required by state or federal law.

Examples of when we may release such information as required by law are as follows:
A. upon your express written consent;
B. when a child under the age of 18 is an Enrolled Dependent through a custodial parent, non-custodial parent, step-parent or legal guardian, except when the minor child has lawfully obtained Covered Health Services without the consent or notification of a parent or legal guardian;
C. under a statute or court order for the protection of evidence or the discovery of evidence; or
D. in the event of litigation between you and PHP in which the information is pertinent.

We may claim any legal right against disclosure of the information that the Provider who supplied it may claim.

Records

The Group shall furnish us with all information and proof that we may reasonably require with regard to any matters pertaining to the Contract.

The following items shall be open for our inspection at any reasonable time:
A. all documents furnished to the Group by a Member in connection with the Coverage;
B. the Group's payroll records; and
C. any other records pertinent to Coverage under the Contract.

Both PHP and Par Providers may charge you reasonable fees to cover costs for completing medical abstracts or for other forms which you request.

Examination of Members

We may reasonably require that you be examined if a question or dispute about the provision of or payment for Health Services arises. The exam will be performed by a Par Doctor acceptable to us. We will pay for the exam.

Typographical Error or Administrative Error

Typographical or administrative errors shall not deprive a Member of benefits. Neither shall any such errors create any rights to additional benefits not in accordance with all of the terms, conditions, limitations, and exclusions of the Contract. A typographical or administrative error shall not continue Coverage beyond the date it is scheduled to terminate according to the terms of the Contract.

Right of Recovery

If we pay for any reason, including due to a typographical or administrative error by the Group or us, for Health Services or benefits that, according to the terms of the Contract, should not have been paid, we reserve the right to recover such amounts from the Member, the Provider to whom they have been paid, or any other appropriate party. The recovery process must be initiated no later than two years after the payment was made. We will inform the appropriate party of the determination of overpayment by providing notice. The appropriate party has the opportunity to Appeal the determination and if they fail to respond to the notice sooner than thirty (30) days

after the notice is made, elects not to Appeal the determination, or Appeals the determination but the Appeal is not upheld, we may initiate the recovery process of the overpayment.

Oral Statements

No oral statement of any person shall:

A. modify or otherwise affect the benefits, limitations or exclusions of the Contract;
B. convey or void any Coverage;
C. increase or reduce any benefits of the Contract; or
D. be used in the prosecution or defense of a claim under the Contract.

Notice

Our notice to an authorized representative of the Group is deemed notice to all affected Members. Such notice includes notice of the termination of the Contract. The Group is responsible for giving notice to Members.

Our notice is sufficient if mailed to the Group's address shown in our records at the time of the mailing. Notice is deemed delivered when deposited in the United States mail with first class postage prepaid, unless otherwise stated in the Contract.

Your Payment

Your payment for Covered Health Services is limited to any Deductibles and/or Copays/Coinsurance set forth in the Contract. Par Providers have agreed to accept our payment as payment in full, after your payment of the Copays/Coinsurance and/or Deductibles.

You are not responsible for paying for Health Services received in accordance with the Contract, except as stated in the Contract. You are responsible, however, for the cost of any Health Services not Covered by the Contract.

Coverage is subject to:

A. the Subscriber's payment of any required Premium; and
B. the Member's payment of any Copays/Coinsurance and/or Deductible required by the Contract.

Contract is not Worker's Comp Insurance

The Coverage provided under the Contract does not replace, supplement, or provide a substitute for benefits to which a Member is entitled under worker's comp; occupational disease; and similar laws.

The Contract does not Cover Health Services or expenses, directly or indirectly, related to such services that are provided or payable under worker's comp, occupational disease, and similar laws:

A. even if the Member's employer is not properly insured or self-insured under such laws;
B. when a Member refuses to use his or her employer's designated Doctor;
C. when a Member has not abided by the employer's policy for treatment or reporting of a work-related illness/injury.

A Member must contact his or her employer or its worker's comp or occupational disease insurer for the provision or payment of such Health Services and expenses.

Conformity with Statutes

The intent of the Contract is to conform to the applicable laws and regulations in effect on the Contract's effective date. The laws and regulations of the jurisdiction in which the Contract is delivered that are in effect on the Contract's effective date shall apply.

Any Contract provision which, on the Contract's effective date, conflicts with those laws and regulations is hereby

amended to conform to the minimum requirements of such.

Non-Discrimination

In compliance with state and federal law, we shall not discriminate on the basis of age; gender; color; race; national origin; disability; marital status; sexual preference; religious affiliation; or public assistance status.

We shall not discriminate on the basis of whether an advance directive has been executed. Advance directives are written instructions recognized under state law relating to the provision of health care when a person is incapacitated. Examples include living wills and durable powers of attorney for health care.

We shall not, with respect to any person and based upon any health factor or the results of Genetic Screening or Testing:

A. refuse to issue or renew Coverage;
B. cancel Coverage;
C. limit benefits; or
D. charge a different Premium.

ERISA

If the Contract has been purchased to provide benefits under a welfare plan governed by ERISA, the Group is the Plan Administrator as that term is used in ERISA. We will not be named as, nor will we be, the Plan Administrator or a named fiduciary of the Group's health and welfare benefit plan.

Amendments Affecting Retirees

If retirees are Covered, the Group retains the right to modify or eliminate Coverage for retirees at any time in its sole discretion.

General Conditions for Benefits

In the event of any major disaster or war, riot, civil insurrection, epidemic or any other Emergency not within our control:

A. we will Cover Health Services as provided in the Contract to the extent that facilities and personnel are then available; and
B. we shall have no liability or obligation for delay or failure to provide services due to lack of available facilities or personnel.

Definitions

This section defines the terms used throughout the Contract. It is not intended to set forth Covered or non-Covered Health Services.

Actively at Work. A Subscriber who:

A. actively performs his or her regular job duties for the Group; and
B. meets the required minimum hours worked per week as defined by the Group and approved by PHP.

A Subscriber is considered to be Actively at Work:

A. on a regular non-working day if he or she was Actively at Work on the last preceding scheduled workday;
B. during a regular paid vacation;
C. during an absence due to Family and Medical Leave Act (if applicable);
D. during any leave of absence, including but not limited to short term or long term disability or a sabbatical, that does not exceed the timeframe indicated in Exhibit 1 of the Group's Contract; or
E. for the purpose of initial eligibility only, if the cause of the leave of absence is due to an injury or illness.

A Subscriber who has received a severance package is not Actively at Work. A Subscriber who is not Actively at Work ceases to be eligible for Coverage, regardless of the Subscriber's status under the Affordable Care Act and IRS regulations promulgated under Section 4980H of the Code.

Additional Charge. A charge in addition to the Copay the Member is required to pay:

A. to a Par Pharmacy; and
B. for a Covered Brand Name Prescription Drug when a Generic Drug is available.

The Additional Charge is the difference between the price of the Brand Name Drug and the Generic Drug.

Adoption. The date of placement for the purpose of Adoption or the date of the entry of an order granting the adoptive parent custody of the child for purposes of Adoption, whichever is earlier.

Adverse Benefit Determination. A denial, reduction, or termination of a benefit or a failure to provide or make payment for a benefit in response to a Member's request for benefits in accordance with the Grievance procedures described in the Grievances section of this Contract. An Adverse Benefit Determination also includes:

A. eligibility determinations at the Grievance and Appeal level only; and
B. Rescission of Coverage at the Grievance, Appeal and External Appeal level.

AHRQ. Agency for Healthcare Research and Quality.

Allowable Expense. Any health care expense, including Coinsurance or Copays and without reduction for any applicable Deductible, that is covered at least in part under any of the Coverage Plans covering the person for whom the claim is made.

When a Coverage Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

The following are not considered an Allowable Expense under This Plan:

A. an expense or a portion of an expense that is not covered by any of the Coverage Plans;
B. any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Member;
C. items of expense for vision care and Prescription Drugs;
D. the difference between the cost of a private Hospital room and a semiprivate room, unless the stay in a private room is Medically Necessary;
E. the amount of the reduction when benefits are reduced under a Primary Plan because a person does not comply with that plan's provisions related to:

1) second surgical opinions;
2) authorization of admissions or services; and
3) preferred Provider arrangements;

F. if a Member is covered by two or more Coverage Plans that:
1) compute their benefits payments on the basis of:
(a) usual and customary fees;
(b) relative value schedule reimbursement;
(c) other similar reimbursement methodology; or
(d) any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit;
2) provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.

If a Member is covered by:
1) one Coverage Plan that calculates its benefits or services on the basis of:
(a) usual and customary fees;
(b) relative value schedule reimbursement; or
(c) other similar reimbursement methodology; and
2) another Coverage Plan that provides its benefits or services on the basis of negotiated fees;
the Primary Plan's payment arrangement shall be the Allowable Expense for all plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

Alternate Facility. A non-Hospital health care facility that, pursuant to the law of the jurisdiction in which treatment is received:
A. provides one or more of the following on an outpatient basis: surgical services; Emergency Health Services; rehab services; lab services; diagnostic services; or
B. provides on an inpatient or outpatient basis: Behavioral Health and Mental Health or Substance Use Disorder Services.

An Alternate Facility may include an attachment to a Hospital but does not include a Doctor's office.

Ambulance. A vehicle (including ground, air and water) that is used, or is intended to be used, for the purpose of responding to emergency medical situations, transporting emergency patients, and administering emergency medical service to patients before, during, or after transportation.

Amendment. An attached or subsequently provided document, if any, of revisions or additional provisions to the Contract. An Amendment is valid only when signed by an executive officer of PHP.

Appeal. An oral or written request for PHP to change its decision regarding a Grievance.

Approved Inpatient Transitional Care Unit. A Hospital or nursing home facility that:
A. is licensed and operated in accordance with the law of the jurisdiction in which treatment is received;
B. is approved by Medicare as an Inpatient Transitional Care Unit; and
C. is approved by PHP to provide Health Services to Members.

Autism Spectrum Disorder or **ASD.** A neurological condition, including but not limited to Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Basic Health Needs. Health Services necessary to maintain or restore fundamental physical or emotional functions used in sustaining one's own life. Basic Health Needs does not include Health Services that are

intended to help or affect the functioning of or interaction with another individual.

Behavioral Health and Mental Health. A physical or behavioral condition having an emotional or psychological origin or effect. Behavioral Health and Mental Health includes behavioral or emotional disorders, but does not include Substance Use Disorder.

Behavioral Health and Mental Health Services. Services and supplies for the diagnosis and treatment of Behavioral Health and Mental Health that are classified in the ICD or the DSM.

Brand Name Drug. A Prescription Drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

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

Care Taker Services. Services not solely related to the care of a Member including but not limited to:

A. sitter or companion services for the ill Member;
B. transportation; and
C. house cleaning or maintenance.

Certain Health Services. Services that are provided by or under the direction of a Par Doctor; and approved in writing in advance by PHP. The following list is not the full list of Health Services, which can be seen at www.phpni.com, as amended from time to time. Par Providers have received information from us regarding the Health Services:

A. radiology services, such as but not limited to PET scans, CT scans, MRI/MRA scans, nuclear cardiology, nuclear medicine and 3D imaging;
B. inpatient Health Services (facility and professional charges);
C. certain surgical and reconstructive procedures;
D. select Specialty Drugs – for a complete listing, please refer to our website (www.phpni.com);
E. select outpatient surgical or medical procedures as determined by us.

Certificate. This Certificate of Coverage or Evidence of Coverage.

Child Health Supervision Services. Periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with section 3701.505 of the Revised Code.

CHIP. Children's Health Insurance Program, as amended.

Claim Determination Period. A Calendar Year. However, it does not include any part of a year during which a person has no Coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

Clean Claim. A claim submitted by a Provider for payment for health care services provided under This Plan that has no defect, impropriety or particular circumstance requiring special treatment preventing payment.

Closed Panel Plan. Plan that provides health care benefits to Members primarily in the form of services through Par Providers, and that excludes Coverage for services provided by non-Par Providers, except in certain cases detailed in this Certificate.

CMS. Centers for Medicare and Medicaid Services.

COBRA. Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Definitions

Coinsurance. A percentage of Eligible Expenses that you must pay for certain Covered Health Services. (Also see Copay.)

Complications of Pregnancy. Conditions that:

A. have diagnoses distinct from uncomplicated Pregnancy; but
B. are adversely affected or are caused by Pregnancy; and
C. usually require inpatient Hospital care.

Examples include: acute nephritis; nephrosis; cardiac decompensation; hyperemesis gravidarum; missed abortion; ectopic Pregnancy; non-elective cesarean section; and similar medical and surgical conditions of comparable severity.

Not included are: false labor; occasional spotting; Doctor prescribed rest during the period of Pregnancy; morning sickness; and pre-eclampsia. Also not included are similar conditions associated with the management of a difficult Pregnancy but not classified in the ICD as Complications of Pregnancy.

Confinement and **Confined.** An uninterrupted stay following formal admission to a Hospital; Inpatient Transitional Care Unit; or Alternate Facility. Confinement and Confined refer to inpatient care.

Congenital Defects and Birth Abnormalities. A defective development or formation of a part of the body:

A. which occurs during Pregnancy;
B. which is determined by a Doctor to have existed at birth, and usually before birth, even though not manifested until later; and
C. does not include abnormalities that occur in the development process after birth.

Congenital Defects and Birth Abnormalities do not include misalignment of the teeth or jaw, except as a result of cleft lip or cleft palate.

Contract. The Contract that includes the following items signed by PHP: the Contract, the Certificate of Coverage; the attachments, the declarations page; Amendments; Exhibits and agreements. Such items constitute the entire agreement regarding the benefits, exclusions and other conditions between PHP and the Group.

Contract Charge. The total Premium for all Subscribers and Enrolled Dependents.

Contract Month. Calendar month.

Contract Years. The time from:

A. the effective date of the Contract to the renewal date set forth in Exhibit 1 of the Group's Contract; and
B. each renewal date to each annual renewal anniversary thereafter.

Coordination of Benefits or **COB.** A provision:

A. establishing an order in which plans pay their claims; and
B. permitting Secondary Plans to reduce their benefits so that the combined benefits do not exceed the total Allowable Expense.

Copays or **Copay.** A dollar amount that you must pay directly to a Provider for certain Covered Health Services. Such dollar amount is in addition to the Premium. (Also see Coinsurance.) Copays do not count toward the Deductible.

Cosmetic Procedures. Procedures that improve physical appearance but do not correct or materially improve a physical function. Cosmetic Procedures include, but are not limited to, drug treatment, plastic surgery, and nutritional procedures and treatments.

Definitions

Cover. Pay for Health Services to the extent they are Covered under the Contract.

Coverage or **Covered.** Your right to reimbursement for Health Services, subject to the terms, conditions, limitations, and exclusions of the Contract.

Coverage Plan. Any of these that provide benefits or services for, or because of, medical or dental care or treatment:

A. group insurance or group-type coverage whether insured or uninsured. This includes:
   1) prepayment;
   2) group practice or individual practice coverage;
   3) any medical payment section of a homeowner's, tenant's or automobile insurance contract; and
   4) coverage other than school accident-type coverage.
B. coverage under a governmental plan or required or provided by law.

A Coverage Plan does not include a state plan under Medicaid.

Each contract or other arrangement for coverage under A. or B. is a separate Coverage Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Coverage Plan.

Custodial Care. Custodial Care includes:

A. non-health-related services such as assistance in activities of daily living; or
B. health-related services that:
   1) do not seek to cure;
   2) are provided when the medical condition of the Member is not changing; and
   3) do not require administration by skilled, licensed medical personnel or a non-professionally qualified person can be trained to perform.

Deductible. The amount a Member must pay in a Calendar Year for Covered Health Services before PHP will pay. There may be more than one Deductible set forth in the Contract. Copays do not count toward the Deductible.

Dental Care. All services provided by or under the direction of a Dentist. Such services include: preventive care and all other care of teeth and the surrounding tissues; correction of a faulty meeting of the teeth; and surgical procedures that involve the hard or soft tissues of the mouth.

Dentist. Any Doctor of:

A. dental surgery, D.D.S.; or
B. medical dentistry, D.M.D.;

who is duly licensed and qualified to provide Dental Care under the law of the jurisdiction in which treatment is received.

Dependent. A person who is:

A. the Subscriber's legal spouse;
B. a child of the Subscriber who is a son, daughter, adopted child, step-child or a child subject to legal guardianship regardless of support level;
C. a grandchild or other blood relative of the Subscriber who depends on the Subscriber for more than 50% of total support;
D. a child of the Subscriber who is recognized under a QMCSO as having a right to enroll under the Contract.

You must furnish satisfactory evidence of this to us upon our request.

A Dependent child is no longer eligible to be an Enrolled Dependent at the end of the Contract Month in which

the child attains age 26.

An Enrolled Dependent child who is totally disabled prior to reaching the age as above may continue Coverage as provided in Extended Coverage for Disabled Children.

Designated Representative. An individual you have appointed to assist or represent you with a Grievance, Appeal, or External Appeal. This person may include, but not be limited to, Doctors, other Providers, attorneys, friends or family members. You must identify your Designated Representative to us in writing, though, in order to prevent the disclosure of your medical information to unauthorized persons.

Designated Transplant Center of Excellence. The Hospital or Alternate Facility that will render Health Services for a Covered transplant. The Designated Transplant Center of Excellence:

A. is at our discretion;
B. may vary, depending on the type of transplant; and
C. may or may not be located within our Service Area.

Doctor. A person performing Health Services within the scope of his or her license as a:

A. doctor of medicine (MD);
B. doctor of osteopathy (DO);
C. Dentist;
D. podiatrist;
E. chiropractor; or
F. psychologist who has been endorsed as a Health Service provider in psychology by the Ohio State Board of Examiners in Psychology.

DSM. The Diagnostic and Statistical Manual of Mental Disorders.

Durable Medical Equipment or **DME.** Medical equipment that:

A. can withstand repeated use and is not disposable;
B. is used to serve a medical purpose;
C. is generally not useful to a person in the absence of a Sickness or Injury;
D. is appropriate for use in the home; and
E. is the most cost-effective type of medical apparatus appropriate for the condition.

Eligible Expenses. Reasonable and Customary Charges for Health Services incurred while Coverage is in effect which do not exceed the Contract's maximum limit or benefit level.

Eligible Person. The employee or other person of the Group who:

A. meets the Group's eligibility requirements for Coverage specified in PHP's quote and enrollment maintenance system accessible by the Group's Plan Administrator or designee; and
B. resides or works within the Service Area, unless we approve other arrangements.

Emergency. An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

A. place a Member's health or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
B. result in serious impairment to the Member's bodily functions; or
C. result in serious dysfunction of a bodily organ or part of the Member.

Emergency Health Services. Health Services that are:

A. furnished by a Provider within the scope of the Provider's license and as otherwise authorized under law; and

B. needed to evaluate or Stabilize a Member in an Emergency.

Enrolled Dependent. A Dependent who is enrolled for Coverage under the Contract. Except as provided elsewhere in the Contract, a Dependent child is no longer eligible to be an Enrolled Dependent upon reaching the limiting age.

Enrollment Form. An application form for Coverage that PHP has approved.

ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental, Investigational or Unproven. Services, treatments, supplies, drugs, devices, or procedures determined by PHP to be any one or more of the following at the time a Coverage determination for any particular case is made:

A. considered by any government agency or subdivision or the CMS Medicare Coverage Issues Manual to be: experimental; investigational; not reasonable and necessary; or any similar finding. Government agencies and subdivisions include, but are not limited to, the FDA and the AHRQ.
B. not covered under Medicare reimbursement laws, regulations or interpretations, on the basis that such are: experimental; investigational; unproven; not reasonable and necessary; or any similar finding.
C. not approved by the FDA to be lawfully marketed for the proposed use.
D. not identified as appropriate for the proposed use in: the American Hospital Formulary Service; the U.S. Pharmacopoeia Dispensing Information; or the American Medical Drug Evaluations.
E. subject to review and approval by any institutional review board for the proposed use.
F. the subject of an ongoing clinical trial that meets the definition of a Phase I, II, III or IV clinical trial set forth in the FDA regulations (regardless of whether the trial is actually subject to FDA oversight), but does not meet the definition of cancer or other life-threatening disease or condition.
G. not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition for which it is proposed.

Determinations regarding whether a particular service, treatment, supply, drug, device, or procedure is considered to be Experimental, Investigational or Unproven are made by PHP's Medical Director in accordance with PHP procedural guidelines.

External Appeal. A voluntary Appeal process in which an IRO reviews certain Appeal decisions PHP made and determines whether to uphold or reverse them.

FDA. The United States Food and Drug Administration.

Final Internal Adverse Benefit Determination. The upholding of an Adverse Benefit Determination at the conclusion of the internal Appeals process or an Adverse Benefit Determination internal Appeals process has been deemed exhausted.

Formulary. A list of Prescription Drugs that we prefer for dispensing to Members. We will review and change the list from time to time.

Generic Drugs. Prescription Drugs that we classify as Generic Drugs that will be Covered at a generic product level. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Genetic Screening or Testing. A lab test that is a direct test of a person's genes or chromosomes to detect abnormalities, defects, or deficiencies.

Grievance. An oral or written complaint submitted in accordance with our formal Grievance procedure by the Member or on behalf of the Member regarding an Adverse Benefit Determination or any aspect of our

organization relating to the Member.

Group. The employer or other entity with whom PHP has made the Contract.

Habilitation Services. Habilitation Services are those that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not 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 Services. Medical or health care services, whether or not Covered under the Contract, which include but are not limited to: medical evaluation; diagnosis; treatments; procedures; drugs; therapies; devices; and supplies.

Home Health Agency. An agency or organization that:
A. is engaged in providing Home Health Care Services; and
B. is authorized to do so under the law of the jurisdiction in which treatment is received.

Home Health Care Services. Health Services provided by a Home Health Agency.

Hospice Care Agency. An agency or organization that:
A. is certified to render Hospice Care;
B. provides twenty-four (24) hour care, seven (7) days a week;
C. is under the direct supervision of a Par Doctor; and
D. maintains written records of the services provided.

Hospice Care and Services. A program of care that:
A. is provided by a licensed Hospice Care Agency;
B. focuses on palliative rather than curative treatment; and
C. provides supportive measures to a Member with a prognosis of less than six (6) months to live.

Hospice Facility. A facility that:
A. is licensed and operated in accordance with the law of the jurisdiction in which treatment is received; and
B. provides twenty-four (24) hour nursing services.

Hospital. An institution that:
A. is operated under the law;
B. is primarily engaged in providing Health Services on an inpatient basis;
C. provides for the care and treatment of injured or sick individuals;
D. has medical, diagnostic and surgical facilities;
E. is operated by or under the supervision of a staff of Doctors;
F. has twenty-four (24) hour nursing services; and
G. is licensed as a Hospital in the jurisdiction in which it operates.

A Hospital is not primarily a place for rest, Custodial Care, or care of the aged. A Hospital is not an Inpatient Transitional Care Unit, nursing home, convalescent home or similar institution.

ICD. The International Classification of Diseases of the United States Department of Health and Human Services.

Independent Review Organization or **IRO.** An organization licensed by the Ohio Department of Insurance to conduct External Appeals.

Infertility. The documented inability of an otherwise healthy Member (male or female) to conceive or to produce conception.

Injury. Bodily damage, other than Sickness, including all related conditions and recurrent symptoms.

In-Network Benefits. Benefits paid for:
A. Health Services rendered by Par Providers; and
B. Emergency and Referred Health Services rendered by non-Par Providers.

Such benefits are usually higher than the Out-of-Network Benefits paid for most Health Services rendered by non-Par Providers. Some Health Services are Covered only under In-Network Benefits.

Maternity Services. All Health Services related to Pregnancy including:
A. prenatal and postnatal care, including newborn hearing test;
B. childbirth; and
C. early termination of Pregnancy.

Medicaid. Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs, as amended from time to time.

Medical Director. A licensed Doctor of medicine or osteopathy employed or contracted by PHP to provide medical review of Health Services proposed or rendered for Members.

Medically Necessary. Health Services that are determined by PHP to be ***all*** of the following:
A. medically appropriate and necessary to meet the Member's Basic Health Needs;
B. the most cost-effective method of treatment and rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Health Service;
C. consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;
D. accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered at a frequency and duration considered by the medical community as medically appropriate;
E. required for reasons other than the comfort or convenience of the Member or his or her Doctor;
F. of a demonstrated medical value in treating the condition of the Member; and
G. consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

The definition of Medically Necessary used in the Contract:
A. relates only to Coverage; and
B. may differ from the way in which a Doctor engaged in the practice of medicine may define Medically Necessary.

The fact that a Doctor has performed or prescribed a Health Service does not mean that it is Medically Necessary. Nor does the fact that a particular Health Service may be the only option available for a particular condition mean that it is Medically Necessary. We retain the right to make all final determinations as to which Health Services are Medically Necessary, subject to the procedures specified in the Grievances section of the Contract.

Medicare. The Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act, as amended from time to time.

Member. A person who:
A. meets all eligibility requirements of the Contract; and
B. is enrolled for Coverage under the Contract.

The term Member refers to either the Subscriber or an Enrolled Dependent but only while the person is Covered under the Contract. References to "you" and "your" throughout the Contract are references to a Member.

Minimum Essential Coverage. As defined in Section 5000A(f) of the Internal Revenue Code, which includes, but is not limited to any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program; coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State (i.e., a qualified non-grandfathered health plan); coverage under a grandfathered health plan; and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of the Health and Human Services recognizes

Office Administered Specialty Drugs. A list of drugs established by us that have specific characteristics, such as but not limited to:

A. they must be administered or infused in a clinical setting under the guidance of a licensed medical professional;
B. they must be Prior Authorized if Out-of-Network;
C. they are injectable;
D. they are high in cost; and
E. they have special handling requirements.

We will review and change the list from time to time.

Open Enrollment Period. A period of time, as determined by PHP and the Group, during which Eligible Persons may enroll themselves and their Dependents under the Contract.

Orthotic Appliance. An appliance or apparatus used to support, align or correct deformities or to improve the function of movable parts of the body, such as but not limited to braces or splints.

Orthotic Device. A Medically Necessary custom fabricated brace or support that is designed as a component of a prosthetic arm, hand, leg or foot.

Ostomy Supplies. Supplies used for the care of an artificial stoma or opening into the urinary, gastrointestinal canal and/or the trachea.

Out-of-Network Benefits. Benefits paid for Health Services rendered by non-Par Providers, except for Emergency and Referred Health Services. Such benefits are usually less than the In-Network Benefits paid for comparable Health Services rendered by Par Providers. Some Health Services are Covered only under In-Network Benefits.

Out-of-Pocket Limit or Total Out-of-Pocket Limit. The maximum amount of Coinsurance a Member must pay each Calendar Year for Covered Health Services. Once this limit is met, Coinsurance for such services is not required for the rest of that Calendar Year. Copays count toward the Out-of-Pocket Limit. There may be more than one Out-of-Pocket Limit set forth in the Contract.

Par Mail Order Drug Provider. A drug vendor that has entered into an agreement with us to provide Prescription Drugs by mail to Members.

Par Pharmacy. A pharmacy that has entered into an agreement with us to provide Prescription Drug services to Members.

Participating or **Par.** Having entered into an agreement with PHP to provide Health Services to Members. We reserve the right to make changes in our Par Provider network that we believe are appropriate or necessary.

PHP. Physicians Health Plan of Northern Indiana, Inc. References to "we," the "Plan," "us," and "our" throughout

the Contract are references to PHP.

Post-service Grievance. Any Grievance that involves only the payment or reimbursement of the Eligible Expenses for Health Services that have already been provided.

Pregnancy. A condition of a female after conception until the birth of the baby.

Premium. The fee we charge for each Subscriber and Enrolled Dependent and which is based on both Subscriber and Group contributions. The Premium is paid in consideration for the benefits and services provided by PHP under the Contract.

Prescriber. A Provider who is duly licensed by the state to prescribe drugs in the ordinary course of his or her professional practice.

Prescription. The authorization issued by a Prescriber for a Prescription Drug.

Prescription Drug. A drug that:

A. has been approved by the FDA; and
B. under federal or state law can only be dispensed with a Prescription.

These are known as legend drugs. For purposes of this Contract, Prescription Drugs also include insulin; diabetic supplies; and inhaler aid devices.

Prescription Order or **Refill.** Referred to herein as Prescription Order. The filling of a Prescription by a pharmacy, according to the specifications of the Prescription.

Pre-service Grievance. A Grievance that must be decided before a Member can obtain Health Services Covered under the Contract.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether a Coverage Plan is a Primary Plan or Secondary Plan.

When a Coverage Plan is a Primary Plan:

A. its benefits are determined before those of another Coverage Plan covering the Member; and
B. it will not consider the other Coverage Plan's benefits.

When a Coverage Plan is a Secondary Plan:

A. its benefits are determined after those of another Coverage Plan covering the Member; and
B. its benefits may be reduced because of the other Coverage Plan's benefits.

When more than two Coverage Plans cover a Member:

A. This Plan may be a Primary Plan as to one or more other Coverage Plans; and
B. This Plan may be a Secondary Plan as to a different Coverage Plan or plans.

Prior Authorization or Prior Authorized. The process of obtaining prior approval from us for Health Services, including for Coverage of certain Prescription Drugs prior to dispensing, using our guidelines.

Prior Carrier Deductible Credit. Your Deductible under this Contract will be credited with any Deductible you accumulated when receiving services from a Participating Provider under the Group's prior contract during this Calendar Year if:

A. this Contract is replacing another contract issued to the Group; and
B. appropriate notification is received by PHP within ninety (90) days of the effective date of Coverage.

Provider. A Doctor; Hospital; Inpatient Transitional Care Unit; Home Health Care Agency; pharmacy; Mail Order Drug Provider; or other health care institution or practitioner. The Provider must be licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received.

QMCSO. A qualified medical child support order as defined in 29 U.S.C. § 1169(a)(2)(A) as amended from time to time. Such an order requires a parent to provide health coverage for a child.

Reconstructive Surgery. Any surgery incidental to:

A. an Injury;
B. a Sickness; or
C. Congenital Defects and Birth Abnormalities.

Reconstructive Surgery for Congenital Defects and Birth Abnormalities includes but is not limited to orthodontic and oral surgery involved in the management of cleft lip and cleft palate for a Member.

Reconstructive Surgery includes the following for a Covered mastectomy:

A. all stages of reconstruction of the breast on which the mastectomy was performed;
B. surgery and reconstruction of the other breast to produce symmetry; or
C. breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act;

in the manner determined by the attending Doctor and the Member to be appropriate, subject to the provisions of the Contract.

Recovery. An amount owed by a Recovery Source pursuant to a settlement, judgment or otherwise.

Recovery Source. The following persons or entities are referred to as Recovery Sources:

A. any person alleged to have caused a Member to suffer injuries or damages;
B. the employer of a Member; or
C. any person or entity obligated to provide benefits or payments to a Member. This includes, but is not limited to, uninsured or underinsured motorist protection and liability insurance.

Referred or **Referral.** Both A. and B. must be present in order to have a Referral:

A. a Par Doctor's written request on behalf of a Member for Coverage of Health Services provided by a non-Par Provider; and
B. our written approval of such Health Services prior to the time they are rendered.

Rehabilitation Services. Health care services that help you restore skills and functioning for daily living that you once had, but lost because of illness or injury. These services may include physical and occupational therapy, speech-language pathology or other rehabilitation services in a variety of inpatient and/or outpatient settings.

Rescission of Coverage. A cancellation or discontinuance of Coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay the required Premium.

Respite Care. Care furnished during a period of time when a Member's usual caretaker cannot, or will not, attend to that Member's needs.

Routine Immunization. An immunization administered to the age-appropriate general population and recommended by the:

A. Centers for Disease Control and Prevention (CDC);
B. American Academy of Pediatrics; and
C. American Academy of Family Physicians.

Self-Administered Specialty Drugs. A list of drugs established by us that have one or more of the following

characteristics, such as but not limited to:

A. they are obtained from a pharmacy;
B. they must be Prior Authorized;
C. they are generally injectable;
D. they are administered at home or without the supervision of a licensed medical professional;
E. they are high in cost;
F. they have special handling requirements; and/or
G. they require special training in order to use.

We will review and change the list from time to time.

Semi-private Room. A room with two or more beds in a Hospital; an Approved Inpatient Transitional Care Unit; or an Alternate Facility.

Service Area. The geographic area served by PHP, as approved by the Ohio Department of Insurance. This area includes: Allen; Defiance; Mercer; Paulding; Van Wert; and Williams counties in Ohio.

Sexual Dysfunction. A condition that interferes with sexual relations, such as but not limited to: pain; sexual arousal; or erectile disorder.

Sickness. A physical illness, disorder, disease, or Pregnancy. Sickness does not include Behavioral Health and Mental Health conditions.

Specialty Drugs. A list of Office Administered Specialty Drugs and Self-Administered Specialty Drugs established by us. We will review and change the list from time to time.

Specialty Pharmacy. A Par Pharmacy that has entered into an agreement with us to provide Specialty Drug services to Members.

Stabilize. To provide Health Services to a Member in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of the Member's condition is not likely to occur.

This includes Emergency Health Services provided to a Member in a Hospital's care setting throughout or during the following: discharge; transfer to another health care facility; or transfer to the Hospital's inpatient setting.

Step Therapy. Means:

A. an alternate but appropriate Prescription Drug identified by the Plan is used first by the Member within a specified number of days; and
B. certain Prescription Drugs are Covered only if the Member has gone through the Step Therapy process.

The identified Prescription Drugs and the process are subject to periodic review and modification by PHP in its discretion.

Subscriber. An Eligible Person who enrolled for Coverage under the Contract. The term Subscriber does not include Enrolled Dependents.

Substance Use Disorder. Alcoholism and chemical or drug dependency.

Teleconsultation Services or Remote Patient Monitoring. The Provider-initiated use of digital technologies to collect medical and other forms of health data from Members in one location and electronically transmit that information securely to Providers in different locations for assessment and recommendations.

Telehealth Services. Member-initiated Health Care Services provided through the use of information and

communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located: the patient receiving the services or another health care professional with whom the Provider of the services is consulting regarding the patient. Telehealth Services include secure videoconferencing and interactive audio communications. We will determine if the services delivered fall under the definition of "Telehealth Services." Health Services that can be delivered through the use of Telehealth Services may include the following:

A. medical exams and consultations; or
B. behavioral health, including substance abuse evaluations and treatment.

The term "Telehealth Services" does not include:

A. electronic mail;
B. facsimile communication;
C. internet questionnaire;

This Plan. The part of the Contract that provides benefits for health care expenses.

Urgent Care. The treatment of an unexpected Sickness or Injury that is not life or limb threatening but requires prompt medical attention not through the use of an Emergency Room.

Urgent Care Center. A licensed medical service center that provides Urgent Care.

Urgent Care Claim. Request for a Health Service that, if subject to the time limits applicable to Pre-service Claims:

A. would seriously jeopardize your life, health or ability to reach and maintain maximum function; or
B. in the opinion of physicians familiar with your condition, would subject you to severe pain that cannot be adequately managed unless we approve the Claim.

Once identified as such, an Urgent Care Claim will be subject to only one review before becoming eligible for the External Appeal process described herein.