ILLNESS & INJURY COMPREHENSIVE HEALTH coverage from Philadelphia American (PALIC)

BENEFITS

- Your PALIC IDs cards and policies will be mailed directly to you. You will receive separate policies and ID cards for each plan you have stacked and you should receive them 7 to 10 working days after your approval date. You should read your all policy information carefully.
- To file a claim with PALIC simply complete a **claim form**, attach the medical bill and submit to PALIC. You can find **claims instructions here**. However, you can also simply provide the provider your ID card and have the provider file the claim. Your choice.
- **Make sure your provider knows that you have PHCS/Multiplan – that's where the provider files the claim, not the insurance company.** When a claim is filed (either by you or the provider), PALIC automatically processes the claim against all of the policies that you have stacked together. That way you only have to file the claim once.
- Don't forget this definition: ***'Pre-Existing condition means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.'***

PRE-EXISTING CONDITIONS

- We will not provide benefits for any loss caused by or resulting from, a Pre-Existing Condition. A Pre-Existing Condition is defined as charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment diagnosis, care or advice within the sixty-month period immediately preceding such Person's Effective Date are excluded for the first 12 months of coverage here under.
- Pre-existing conditions include conditions that produced any symptoms which would have caused a reasonable person to seek diagnosis, care or treatment within the sixty-month period immediately prior to the coverage effective date. (The Pre-Existing Conditions Limitation varies by state and the look back period for the pre-existing condition may be less than 5 years.)

CLAIMS

1. Policyholder will present PALIC ID Card at the time of service.
2. Doctor/Hospital will verify coverage based on information on card.
3. Charges will be forward to National Claims Clearing House.
4. National Clearing House will electronic forward information to ECOM who will re-price the claim.
5. ECOM will re-price claim and send it electronically into PALIC's Claim System.
6. The PPO discount will be shown on the EOB that is sent along with the claim payment to the provider of service (benefits in most cases are assigned to participating providers).
7. **If the HSP policy pays more than the billed charges less the PPO discount (PPO allowable charge), we will send the provider the PPO allowable amount and reimburse the policyholder the difference.**

Present ID Card to Provider (Most will file claim and will ask client to assign benefits)

If a Provider will not file, instructions are as follows.

1. Provide itemized statement showing full name, address, and Tax ID of the provider.
2. Also the statement must include the date of service, amount for each service, and diagnosis/procedure codes.
3. ER or Outpatient Hospital visits must include 3 digit Revenue Codes.
4. Copy of EOB must be supplied!!!
5. Name and policy number must appear on all documents.