Everything you need to know about your health plan

Keystone HEALTH PLAN EAST

Independence

Independence

Welcome to Independence Blue Cross

Our goal at Independence Blue Cross is to provide you with health care coverage that can help you live a healthy life. This Welcome Kit will help you understand your benefits so that you can take full advantage of your membership.

To get the most from your coverage, it's important to become familiar with the benefits and services available to you. You'll find valuable information in this Welcome Kit on:

- how to use your ID card;
- what services *are* and *are not* covered by your health insurance;
- how decisions are made about what is covered;
- how to use our member website, ibxpress.com;
- how to get in touch with us if you have a problem.

Although this Welcome Kit will answer many of your questions, your benefits administrator is also a great resource. Your benefits administrator manages your health benefit plan and will be notified if there are any changes.

You may also register on our member website, ibxpress.com, or download the free IBX app to your iPhone or Android phone, which helps you make the most of your health plan with easy access to your health info 24/7, wherever you are.

If you have any other questions, feel free to call Customer Service at 1-800-ASK-BLUE (1-800-275-2583) and we will be happy to assist you.

Again, thank you for being a member of Independence Blue Cross. We look forward to providing you with quality health care coverage.

Sincerely,

Renee J. Rhem

Renee J. Rhem
Vice President, Customer Service

Welcome Kit Overview

How your plan works

Using your Prescription RX benefits

Using your Vision benefits

How to read your Explanation of Benefits

Benefits Booklet

Notice of Privacy Practices

Introduction to your health plan

What is a primary care physician?

You have a Keystone Health Plan East HMO, which means you must choose a primary care physician (PCP) who will coordinate the overall medical care for you and your covered dependents. Your PCP is the doctor that will treat you for your basic health care needs.

Anytime you need to see a specialist, such as a cardiologist or dermatologist, your PCP will refer you to a specialist participating in the network. PCPs choose one radiology, physical therapy, and laboratory site to which they send their patients. If you need a service your PCP doesn't provide, like diagnostic testing or hospitalization, your PCP will refer you to an in-network facility.

How you choose or change your PCP

To select or change your PCP, search our provider network. Visit www.ibx.com/providerfinder where you can search by specialty (for example internal medicine or pediatrics), location, gender preference, and distance.

There are two ways to choose or change your PCP:

Online: To select or change your doctor, visit www.ibxpress.com, our simple, convenient, and secure member website. Click on the *My Benefits* tab and then on the *Change Primary Care Physician* link.

Phone: Call 1-800-ASK-BLUE (1-800-275-2583) and one of our Customer Service associates will take your PCP selection over the phone.

Using your ID card

You and your covered dependents will each receive an Independence Blue Cross identification (ID) card. It is important to take your ID card with you wherever you go because it contains information like what to pay when visiting your doctor, specialist, or the emergency room (ER), and your PCP's contact information. You should present your ID card when you receive care, including doctor visits or when checking in at the ER.

The back of your ID card provides information about medical services, what to do in an emergency situation, and how to use your benefits when out of network.

If any information on your ID card is incorrect, you misplace an ID card, or need to print out a temporary ID card, you may do so through ibxpress.com, our member website. You may also call 1-800-ASK-BLUE (1-800-275-2583) and we will issue you a new ID card.

Got Questions?

Call 1-800-ASK BLUE
(1-800-275-2583)

Independence

Benefit booklet

We've improved the benefit booklet so that you will find it easy to understand your Independence Blue Cross membership. Here are a few highlights:

- It's more reader friendly.
- Topics are categorized and in alphabetical order so you can find what you're looking for faster.
- The schedule of covered services clearly states your costs.

IBX Wire

When you receive your ID card, call the toll-free number on the sticker affixed to the card to confirm receipt. You will also be given the option to sign up for IBX Wire, a free messaging service. IBX Wire is an innovative way for you to receive timely and helpful communications on your smartphone. If you choose to opt in, you will have access to a private message board and will receive text messages about once every other week that communicate helpful, relevant information about your health plan, maximizing your benefits, and wellness programs.

Sign up for IBX Wire

When you receive your ID card, opt in to IBX Wire to receive text messages about your health plan.

Scheduling an appointment

Simply call your doctor's office and request an appointment. If possible, call network providers 24 hours in advance if you are unable to make it to a scheduled appointment.

Referrals

You are required to get a referral from your PCP for specialty services. All referrals are done electronically, so you can get the care you need as quickly and conveniently as possible. You won't need a referral for OB/GYN care, mammograms, mental health, or routine eye care. You may also check the status of your referral by logging on to ibxpress.com or on your iPhone or Android through the IBX App.

Locating a network physician or hospital

You have access to our expansive provider network of physicians, specialists, and hospitals. You may search our provider network by going to www.ibx.com/providerfinder. You may search by specialty (e.g. internal or pediatrics), location, gender preference, and distance. You may also call 1-800-ASK-BLUE (1-800-275-2583) and a customer services associate will help you locate a provider.

How to receive care

Using your preventive care benefits

Quality care and prevention are vital to your long-term health and well-being. That's why we cover 100 percent of certain preventive services, offering them without a copayment, coinsurance, or deductible if received from your PCP or other in-network provider.

Covered preventive services include, but are not limited to:

- screenings for:
  - breast, cervical, and colon cancer
  - vitamin deficiencies during pregnancy
  - diabetes
  - high cholesterol
  - high blood pressure
- routine vaccinations for children, adolescents, and adults as determined by the CDC (Centers for Disease Control and Prevention).
- women's preventive health services, such as:
  - well-woman visits (annually);
  - screening for gestational diabetes;
  - human papillomavirus (HPV) DNA testing;
  - counseling for sexually transmitted infections;
  - counseling and screening for human immunodeficiency virus (HIV);
  - screening and counseling for interpersonal and domestic violence;
  - breastfeeding support, supplies (breast pumps), and counseling;
  - generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved over-the-counter female contraceptives with a prescription.

Be sure to consult with your PCP for preventive services and/or screenings.

Wellness Guidelines

One of the best ways to stay well is to utilize the preventive services covered by your health plan, such as well visits, immunizations, and health screenings. A recommended schedule of wellness visits to your health care provider is outlined in our Wellness Guidelines*. Additional resources along with tips to stay healthy and safe and topics to discuss with your health care provider are included.

To download our Wellness Guidelines, log on to www.ibxpress.com and click on the *Health & Wellness Programs* tab. Then click on *Early Detection,* and then on *Wellness Guidelines.* You can also request a hard copy of the Wellness Guidelines by calling 1-800-ASK-BLUE (1-800-275-2583).

*The Wellness Guidelines are a summary of recommendations based on the U.S. Preventive Services Task Force and other nationally recognized sources. These recommendations have been reviewed by our network health care providers. This information is not a statement of benefits. Please refer to your health benefit plan contract/member handbook or benefits handbook for terms, limitations, or exclusions of your health benefits plan. Please contact our Customer Service department with questions about which preventive care benefits apply to you. The telephone number for Customer Service can be found on your ID card.

Emergency care

In the event of an emergency, go immediately to the emergency room of the nearest hospital. If you believe your situation is particularly severe, call 911 for assistance.

A medical emergency is typically thought of as a medical or psychiatric condition in which symptoms are so severe, that the absence of immediate medical attention could place one's health in serious jeopardy. Most times, a hospital emergency room is not the most appropriate place for you to be treated.

Hospital emergency rooms provide emergency care and must prioritize patients' needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you could wait a long time.

Urgent Care

Urgent care is necessary treatment for a non-life-threatening, unexpected illness or accidental injury that requires prompt medical attention when your doctor is unavailable. Examples include sore throat, fever, sinus infection, ear ache, cuts, rashes, sprains, and broken bones.

You may visit an urgent care center which offers a convenient, safe, and affordable treatment alternative to emergency room care when you can't get an appointment with your own doctor.

Retail health clinic

Retail health clinics are another alternative when you can't get an appointment with your own doctor for non-emergency care. Retail health clinics use certified nurse practitioners who treat minor, uncomplicated illness or injury. Some retail health clinics may also offer flu shots and vaccinations.

Not sure what facility to use? Go to www.ibx.com/findcarenow to help you decide where to go for care.

You're covered while traveling

You can travel with the peace of mind knowing that Blue goes with you wherever you go. If you need medical care when you are away from home, you should follow these guidelines:

- In a true emergency, go to the nearest ER.
- In an urgent care situation, find a provider in the area. Call 1-800-810-BLUE (1-800-810-2583) to find an in-network provider in the area. You may also visit an urgent care center for medical issues if an in-network provider is unavailable and if you do not require the medical services of an emergency room.
- Prior to visiting a physicians office, it will be necessary for you to obtain a preapproval.

Guest membership

Guest membership is a temporary courtesy enrollment in another HMO (Host) plan that enables members who are living away from home to receive a comprehensive range of medical benefits, including routine and preventive services. A Guest Member remains an IBC member, pays premiums to IBC, but is also enrolled to receive benefits of the host plan while in their service area.

Keystone Health Plan East subscribers may be eligible to be on a Guest Membership for up to a 12 month period (6 months followed by 6 months upon approval of a renewal request). Dependents may be eligible to be on a Guest Membership for a period of up to 12 months without a renewal request. Members who are eligible to participate must also meet the following criteria:

- Long-term traveler — available to qualified HMO subscribers and dependents that are away from home for at least 90 consecutive days (3 months), but not more than 180 days (6 months) or group renewal date.
- Families apart — available to qualified dependents of the subscriber that do not reside in our service area for 90 or more consecutive days.
- Students — available to qualified dependents of the subscribers that are out of our service area for 90 or more consecutive days attending school.

For example

When to go to the ER:
- heart attack
- electrical burn

When to go to an urgent care center:
- sore throat
- ear ache

Out of the area and need care?

Call 1-800-810-BLUE (1-800-810-2583) to find an in-network provider in the area.

Register on ibxpress.com to access your benefits online.

Using services that require preapproval

As a Keystone Health Plan East member, certain in-network services and all out-of-network services require preapproval prior to receiving care to ensure that the service you seek is medically necessary. Since your care is provided by your PCP, all necessary preapprovals will be obtained for you by your PCP.

It is important to understand that preapproval is not the same as the process for receiving referrals from your PCP.

Receiving services for mental health, alcohol, or substance abuse treatment

If you require outpatient or inpatient mental health or substance abuse services, a written referral from your PCP is not necessary. Magellan Behavioral Health administers your Keystone Health Plan East mental health and substance abuse benefits and can be reached by calling 1-800-ASK-BLUE (1-800-275-2583). Refer to the terms and conditions of your group health plan to find out if you have coverage for mental health and substance abuse benefits.

Managing your health with ibxpress.com

On ibxpress.com you can conveniently and securely view your benefits and claims information and use the tools that help you take control of your health. As an Independence Blue Cross member, you and your dependents 18 years of age and older can create your own accounts on ibxpress.com.

Register on ibxpress.com

To register, simply go to ibxpress.com, click *Register,* and then follow the directions. You will need information from your ID card to register, so be sure to have it handy.

Once you're registered, log on to ibxpress.com to:

- view your benefits information;
- review claims information;
- review annual out-of-pocket expenses;
- request a replacement ID card and print a temporary ID card;
- change your PCP;
- view and print referrals;
- download forms.

Online tools to help make informed health care decisions

ibxpress.com also provides you with tools and resources to help you make informed health care decisions:

- **Provider Finder and Hospital Finder** help you find the participating doctors and hospitals that are equipped to handle your needs. Simple navigation helps you get fast and accurate results. Plus, when you select your health plan type your results are customized based on your network, making it easy to locate a participating doctor, specialist, hospital, or other medical facility. You'll even be able to read patient ratings and reviews and rate your doctors and write your own reviews.

- **Symptom checker** provides a comprehensive tool to help you understand your symptoms — and what to do about them.
- **Health Encyclopedia** provides information on more than 160 health topics and the latest news on common conditions.
- **Treatment Cost Estimator** helps you estimate your costs within certain geographic areas for hundreds of common conditions — including tests, procedures, and health care visits, so you can plan and budget for your expenses. You even have access to tools and programs to help you make lifestyle changes by helping you get started, setting reachable goals, and giving you ways to track your progress.
- **Personal Health Profile** gives a clear picture of what you are doing right and ways to stay healthy. After completing the Personal Health Profile, you will receive a confidential and personalized action plan.
- **My Health Assistant** is a personal coaching tool that provides an interactive, targeted approach to healthy behavior change.
- **Health Trackers** allow you to track your blood pressure, cholesterol, body fat, and even exercises.
- **Personal Health Record** helps you store, maintain, track, and manage your health information in one centralized and secure location. Your Personal Health Record is updated once we process claims received from participating providers.

Save money with wellness discounts from Blue365®

You can enjoy exclusive value-added discounts and offers on programs and services from leading national companies. Blue365 gives you an easy-to-use, valuable resource to save on healthy programs and services. Visit www.blue365deals.com to see the latest discounts.

Manage your health on the go with the IBX App

Download the free IBX App for your smartphone to help you make the most of your health plan. The IBX App gives you easy access to your health care coverage 24/7, wherever you are. Use the Doctor's Visit Assistant on the IBX App to:

- view and share your ID card
- check the status of referrals and claims
- access your health history and prescribed medications
- record notes and upload photos of symptoms to discuss with your doctor

The IBX App also offers expanded provider search capabilities and other ways to manage your health on the go:

- find doctors, hospitals, urgent care centers, and Patient-centered Medical Homes
- access benefit information
- track deductibles and spending account balances

Download from the App store or Google Marketplace. Log in to the App with the same username and password you use for ibxpress.com.

Download the IBX App

After you download the IBX App, simply use your ibxpress.com username and password to log in.

Follow us!

www.facebook.com/ibx
www.twitter.com/ibx

Your one-stop shop

ibxpress.com

Connect with us on Facebook and Twitter

If you're one of the millions of Americans who use Facebook or Twitter, you already know what great tools they are for keeping in touch with friends, family, and colleagues. But you may be surprised how they can be great resources to improve your health, too. "Like" the Independence Blue Cross page on Facebook or follow us on Twitter, and you'll find a whole new approach to making healthy lifestyle changes, one step at a time.

- Receive health and wellness tips that can help you improve your well-being.
- Enter contests and promotions.
- Connect with other health-minded fans.
- Learn how to incorporate fitness, good nutrition, and stress management into your everyday life with practical advice.

Customer Support

When you need us, we're here for you. You can contact us to discuss anything pertaining to your health care, including:

- benefits and eligibility
- claims status
- requesting a new ID card
- wellness programs

Email

To send a secure email to Customer Service, log on to www.ibxpress.com and click on the *Customer Service* tab. On the Customer Service page you will see a link that allows you to send your inquiries or comments directly to Customer Service.

Mail

Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

Our walk-in service, located at 1900 Market Street, is open Monday through Friday from 8 a.m. to 5 p.m.

Call

Call 1-800-ASK-BLUE (1-800-275-2583) to speak to one of our experienced Customer Service team members, who are available to answer your questions Monday through Friday, 8 a.m. to 6 p.m.

Services for members with special needs

If a language other than English is your primary language, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583) and they will work with you through an interpreter over the telephone to help you understand your benefits and answer any questions you may have.

If you have trouble hearing or speaking, call 1-888-857-4816 so that Customer Service can assist you through TDD or TTY.

Key terms

You will find key terms and definitions in detail included in the benefit booklet. You may also view the glossary of key terms in Health Care Reform by visiting ibx.com/HCR_Glossary.

Independence

Pharmacy

Using your prescription drug benefits

Find out how to fill prescriptions

Independence Blue Cross Prescription Drug Program

Your prescription drug benefit program, administered by FutureScripts®, an independent company, provides many advantages to help you easily and safely obtain the prescription drugs you need at an affordable cost.

Take a look at the advantages:

- **Easy to use**. A national network of retail pharmacies will recognize and accept your member identification (ID) card.
- **Low out-of-pocket expenses**. When you use a participating pharmacy, your out-of-pocket costs are based on a discounted price, fixed copayments, or coinsurance.
- **No paperwork**. You don't have to file a claim form or wait for reimbursement when you use a participating pharmacy.
- **High level of safety**. When you fill a prescription at a participating pharmacy, your pharmacy can identify harmful drug interactions and other dangers by viewing your drug history.
- For maintenance drugs needed to treat ongoing or chronic conditions
  - **Home delivery**. Your program may allow you to receive drugs right at your door when ordered through the mail order service, eliminating time spent waiting in line at the pharmacy counter.
  - Mail order purchases allow you to get a larger supply of drugs than what might be available to you at the retail pharmacy. And, depending upon your plan design, your out-of-pocket expenses may be lower and you won't have to visit the pharmacy as often.

How to fill your prescription at a retail pharmacy

Present your ID card and your prescription at a FutureScripts participating pharmacy for your plan. The pharmacist will confirm your eligibility for benefits and determine your share of the cost of your prescription. Your doctor may also electronically submit your prescription to your pharmacy.

Find a pharmacy

Visit
www.futurescripts.com
or call 1-888-678-7012.

FUTURE SCRIPTS

Participating pharmacies

A pharmacy is considered participating if it is in the FutureScripts pharmacy network for your plan. The FutureScripts network includes more than 65,000 retail pharmacies. When you're traveling, you will find that most of the pharmacies in all 50 states accept your ID card and can fill your prescription for the same cost you pay at home, if you use a participating pharmacy.

There is no need to select just one pharmacy to fill your prescription needs.

To locate a participating pharmacy, visit www.futurescripts.com or call FutureScripts at 1-888-678-7012.

Non-participating pharmacies

If your prescription is filled at a pharmacy that does not participate in the FutureScripts network for your plan, you will have to pay the pharmacy's regular charge right at the counter. Then, depending on your plan design, you may submit a claim form for partial reimbursement to:

FutureScripts
Dept. #0382
P.O. Box 419019
Kansas City, MO 64141

Your reimbursement check should arrive within 14 days from the day your claim form is received.

Keep in mind that your plan sponsor selected Independence Blue Cross (IBC) and/or its subsidiaries based in part on the discounted drug prices that FutureScripts has negotiated. When you use a non-participating pharmacy that has not agreed to charge a discounted price, it costs your plan more money; part of that cost is passed on to you.

Understanding your prescription

Brand drugs are manufactured by only one company, which advertises and sells its product under a special trade name. In many cases, brand drugs are quite expensive, which is why your share of the cost is higher. Generic drugs are typically manufactured by several companies and are almost always less expensive than the brand drug. Generic drugs are approved by the U.S. Food and Drug Administration (FDA) to ensure they are as safe and effective as their brand counterparts. However, not every brand drug has a generic version.

The Select Drug Program provides our members with comprehensive prescription drug coverage. The Select Drug Program uses a formulary, which includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. The formulary is reviewed quarterly to ensure its continued effectiveness.

To check the formulary status of drugs, simply log onto ibxpress.com.

Brand vs. Generic

Generic drugs are as effective as brand drugs and could save you money. However, consult your doctor to find out which drug type is best for you.

In addition to the Select Drug Program formulary, you will also find helpful information on these related topics:

- Prior authorization process
- Age and gender limits
- Quantity level limits

If you're not sure if brand or generic drugs are right for you, talk to your doctor. The pharmacist may, on occasion, discuss with your physician whether an alternative drug might be appropriate for you. Let your physician know if you have a question about a change in prescription or if you prefer the original prescription. Your physician makes the final decision on the necessity of you getting a brand drug.

Certain controlled substances and other prescribed medications may be subject to dispensing limitations. If you have any questions regarding your medication, please call 1-800-ASK-BLUE (1-800-275-2583).

Preventive drugs for adults and children

IBC's prescriptive drug plans include 100-percent coverage for preventive medications when received from an in-network pharmacy. This means that you won't have to pay copays, coinsurance, or deductibles for certain preventive medications with a prescription from your doctor. Receiving this preventive care will help you stay healthy and may improve your overall health.

For a list of preventive drugs eligible for 100-percent coverage please go to www.ibx.com or call the phone number on the back of your ID card.

Mail order pharmacy

If your doctor has prescribed a medication that you'll need to take regularly over a long period of time, the mail-order service is an excellent way to get a long-lasting supply and reduce your out-of-pocket costs.

Mail order is convenient and safe to use

If you choose mail order, your doctor can prescribe a supply that will last up to 90 days. You can get three times as many doses of your maintenance medication at one time through mail order.

Mail order prescriptions have been safely handled through the mail for many years. When your order is received, a team of registered, licensed pharmacists checks your prescription against the record of all drugs dispensed to you by a FutureScripts network pharmacy for as long as you've been in the IBC program administered by FutureScripts. This process ensures that every prescription is reviewed for safety and accuracy before it is mailed to you.

If there are questions about your prescription, a pharmacist will contact your doctor before your medication is dispensed. Your medication will be sent to your home within ten days from the date your legible and complete order is received.

On-line services

Log on to www.ibxpress.com and click on Manage My Prescription Drugs to take advantage of convenient features, such as:

- network pharmacy search
- formulary search
- claims information
- mail-order refill requests

If you have any questions about your IBC Prescription Drug program, call:

1-800-ASK-BLUE (1-800-275-2583).

There may be times when you need a prescription right away. On these occasions, you should have your prescription filled at a local participating pharmacy. If you need medication immediately, but you will be taking it on an ongoing basis, ask your doctor to write two separate prescriptions: you can have the first prescription filled locally for an initial 30-day supply of your medication, and you can send the second prescription to FutureScripts for a 90-day supply provided through the mail.

How to begin using mail order pharmacy:

1. When you are prescribed a chronic or "maintenance" drug therapy, ask your doctor to write the prescription for a 90-day supply, plus refills. Make sure your doctor knows that you have a mail-order service so that you get one 90-day prescription and not three 30-day prescriptions, because the cost of the three 30-day prescriptions may be more than the cost for one 90-day prescription. If you're taking medication now, ask your doctor for a new prescription.
2. Complete the *FutureScripts Mail Service Order Form* with your first order only. Forms and envelopes are available by calling the number on your ID card.
3. Be sure to answer all the questions, and include your member ID number. An incomplete form can cause a delay in processing. Send the completed *Mail Service Order Form,* your original 90-day prescription, and the appropriate payment to FutureScripts.
4. Your mail order request will be processed and your medication sent to you within ten days from the day you mail your order, along with instructions for future refills. Standard shipping is via U.S. Mail and is free of charge. Narcotic substances and refrigerated medicines will be shipped by FedEx® at no additional charge.

You will be dispensed the lower-priced generic drug (if manufactured) unless your doctor writes "brand medically necessary" or "dispense as written" on your prescription, or you indicate that you do not want the generic version of your brand drug on the *Mail Service Order Form.* A *Mail Service Order Form* and envelope will be included with each mail order delivery.

Paying for mail order services

Your payment can be a check or money order (made payable to FutureScripts), or you can complete the credit card portion of the *Mail Service Order Form*. FutureScripts accepts Visa, MasterCard®, Discover®, and American Express®. Please do not send cash. If you are uncertain of your payment, call the number on your ID card. If the payment you enclose is incorrect, you will be sent either a reimbursement check or an invoice, as appropriate.

Mail order refills

When you receive a medication through the mail order service, you will also receive a notice showing the number of refills allowed by your doctor. To avoid the risk of being without your medication, mail the refill notice and your payment two weeks before you expect your present supply to run out. You can also manage and order your refills online through ibxpress.com.

The refill notice will include the date when you should reorder and the number of refills you have left. Remember, most prescriptions are valid for a maximum of one year. Please note: PRN (take as needed) refills in the Commonwealth of Pennsylvania are limited to five times or six months, whichever is less.

If you have any questions concerning this program, please contact FutureScripts at 1-888-678-7012.

Self-administered Specialty Drug Coverage

Self-injectables and other oral specialty drugs that can be administered by you, the patient, or by a caregiver outside of the doctor's office are covered under your IBC prescription drug benefits administered by FutureScripts. You may fill your prescription via the FutureScripts Specialty Pharmacy Program.

The administration of a self-injectible drug by a medical professional is covered under your IBC medical benefit, even if you obtained the self-injectable through the FutureScripts Specialty Pharmacy Program. However, the drug itself will be covered under your IBC prescription drug benefit.

The only self-injectable drugs that are covered under IBC medical plans include drugs that:

- are required by law to be covered under both medical benefits and pharmacy benefits (for example, insulin);
- are required for emergency treatment, such as self-injectables that counteract allergic reactions.

An independent pharmacy benefits management (PBM) company, FutureScripts, administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Independence Blue Cross anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits.
Under most benefit plans, prescription drugs are subject to a member copayment.
Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.
FutureScripts, a Catamaran company, is an independent company that provides pharmacy benefit management services.

Independence

Vision

The clear solution to your vision care needs

Use your Vision benefits

Vision problems are among the most prevalent health issues in the United States. Nearly 176 million American adults wear some form of vision correction.* An eye exam can help prevent vision problems and help detect more serious chronic health conditions, such as diabetes, hypertension, and heart disease.

Your vision plan gives you access to timely treatment and covered services like refraction, glaucoma screenings, and dilation that will help paint a picture of your overall health.

Freedom of provider choice

You have access to the Davis Vision provider network, which includes more than 40,000 ophthalmologists, optometrists, and regional and national retailers, including Visionworks.

Choose from an extensive frame collection

You can select any frame from the Exclusive Frame Collection of stylish, contemporary frames covered in full, or with a minimal copay. You also have the freedom to use your frame allowance at any network location toward any frame on the market today. This includes Visionworks, which has over 2,000 frames to choose from in store.

The Frame Collection features over 200 of the latest frames to mirror the fit, function, and fashion needs of today's vision care consumer. Every frame or lens purchased at a participating provider is backed by an unconditional one-year breakage warranty for repair or replacement.

Coverage for contacts and laser vision correction

You can purchase replacement contact lenses through LENS123®, a mail-order contact lens replacement program. LENS123 will ship replacement contact lenses or solution anywhere the same day and you are guaranteed low prices.

If you're interested in Laser Vision Correction, you can receive up to *25 percent off* a participating provider's usual and customary fees, or *5 percent off* any participating provider's advertised specials on laser vision correction services.

You can also view your benefits online through ibxpress.com. You can:

- check eligibility;
- locate a participating provider;
- view the Davis Vision Collection of frames.

View your benefits online

visit www.ibxpress.com

DAVIS VISION THE EYECARE ADVANTAGE

Visionworks retail centers offer affordability, choice, and convenience

Visionworks optical retail centers are a cornerstone of the provider network and support IBC's commitment to choice. Visionworks retail centers are located across the Philadelphia five-county area, surrounding counties, and states, making it convenient to find one close to you.

Visionworks has high-quality eyeglasses, designer frames, and a wide variety of contact lenses, reading glasses, and specialty lenses all at great prices. With a dedication to quality, durability, and variety, Visionworks provides you with all you need to find the right look. Visionworks also has one of the largest selections of fun and fashionable kids eyeglasses in the eyewear industry. Kids 13 and younger receive free impact and scratch-resistant lenses.

With your IBC Vision Care benefits, you will receive:

- high-quality designer and exclusive brands frames;
- eyeglass lenses;
- contact lenses;
- sunglasses;
- vision correction.

To find a Visionworks near you, go to www.visionworks.com.

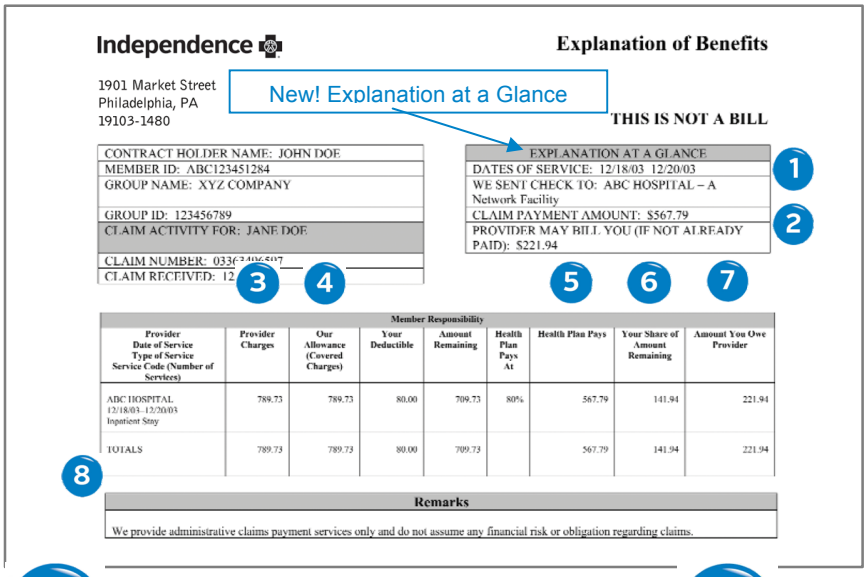
If you have any questions about your IBC Vision Care, call **1-800-ASK-BLUE** (1-800-275-2583).

*VisionWatch - The Vision Council Member Benefit Reports, The Vision Council & Jobson, 12ME September 2009

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association. IBC Vision Care is administered by Davis Vision, an independent company. An affiliate of Independence Blue Cross has a financial interest in Visionworks

How to read your Explanation of Benefits

Our Explanation of Benefits statements (commonly referred to as an EOB) help you understand your out-of-pocket costs when you receive covered services. The easy-to-read format lets you quickly find out how much a doctor, hospital, or other health care facility charged for services, what your Independence Blue Cross (IBC) health plan paid, and how much you owe.



Independence

Explanation of Benefits

1901 Market Street
Philadelphia, PA
19103-1480

New! Explanation at a Glance

THIS IS NOT A BILL

CONTRACT HOLDER NAME: JOHN DOE
MEMBER ID: ABC123451284
GROUP NAME: XYZ COMPANY
GROUP ID: 123456789
CLAIM ACTIVITY FOR: JANE DOE
CLAIM NUMBER: 033[illegible]
CLAIM RECEIVED: 12

EXPLANATION AT A GLANCE
DATES OF SERVICE: 12/18/03 12/20/03
WE SENT CHECK TO: ABC HOSPITAL – A Network Facility
CLAIM PAYMENT AMOUNT: $567.79
PROVIDER MAY BILL YOU (IF NOT ALREADY PAID): $221.94

Member Responsibility

Provider Date of Service Type of Service Service Code (Number of Services)	Provider Charges	Our Allowance (Covered Charges)	Your Deductible	Amount Remaining	Health Plan Pays At	Health Plan Pays	Your Share of Amount Remaining	Amount You Owe Provider
ABC HOSPITAL 12/18/03–12/20/03 Inpatient Stay	789.73	789.73	80.00	709.73	80%	567.79	141.94	221.94
TOTALS	789.73	789.73	80.00	709.73		567.79	141.94	221.94

Remarks

We provide administrative claims payment services only and do not assume any financial risk or obligation regarding claims.

1 2 3 4 5 6 7 8

1 **We Sent Check to:** Individual/facility that received the IBC reimbursement check.

2 **Provider May Bill You:** Summary of what you owe the provider. The individual breakdown is shown in the Member Responsibility section.

3 **Provider Charges:** The amount the provider actually charged for services.

4 **Our Allowance**: Amount covered by IBC.

5 **Health Plan Pays:** The actual dollar calculation of the amount IBC pays.

6 **Your Share of Amount Remaining:** The amount remaining after IBC's payment has been subtracted.

7 **Amount You Owe Provider:** The total of all of member responsibilities. This includes any deductable, coinsurance, or copayment amounts, plus any remaining amounts.

8 **Remarks:** Explains why certain charges were not covered (if any).

Questions about your EOB?

Call the phone number on the back of your member ID card. Be sure to have your member ID number and EOB ready when you call.

New paperless EOB Option

You can view your EOB online at **ibxpress.com** or have it sent to you by email. You can also continue to receive a paper copy by mail. Just log in to **ibxpress.com** and choose *Settings* on your homepage to select your preferences.

KEYSTONE HEALTH BENEFITS PLAN

By and Between

Keystone Health Plan East, Inc
("Keystone" or "the Health Benefit Plan")*
*independent corporation operating under a license
from Blue Cross and Blue Shield Association

A Pennsylvania corporation
Located at:
1901 Market Street
P.O. Box 7516
Philadelphia, PA 19103-7516

And

Group (Contract Holder)
(Called "the Group")

The Health Benefit Plan certifies that the enrolled Employee and the enrolled Employee's eligible Dependents, if any, are entitled to the benefits described in this Evidence of Coverage ("Benefit Booklet"), subject to the eligibility and Effective Date requirements.

This Benefit Booklet replaces any and all Benefit Booklet previously issued to the Member under any group contracts issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

The Contract is between the Health Benefit Plan and the Contract Holder. This Benefit Booklet is a summary of the provisions that affect the Member's Health Benefit Plan. All benefits and exclusions are subject to the terms of the Group Contract.

ATTEST:

Brian Lobley
Senior Vice President
Marketing and Consumer Business

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TABLE OF CONTENTS

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INTRODUCTION

Thank you for joining the Keystone Health Benefits Plan (the Health Benefit Plan). Our goal is to provide Members with access to quality health care coverage. This Benefit Booklet is a summary of Members benefits and the procedures required in order to receive the benefits and services to which Members are entitled. The Members' specific benefits covered by the Health Benefit Plan are described in the ***Description of Covered Services*** section of this Benefit Booklet. Benefits, exclusions and Limitations appear in the ***Exclusions – What Is Not Covered*** and the ***Schedule of Covered Services*** section of this Benefit Booklet.

Please remember that this Benefit Booklet is a summary of the provisions and benefits provided in the Program selected by the Members Group. Additional information is contained in the Group Master Contract ("Contract") available through the Members Group benefits administrator. The information in this Benefit Booklet is subject to the provisions of the Contract. If changes are made to the Members Group's Program, the Member will be notified by their Group benefits administrator. Contract changes will apply to benefits for services received after the effective date of change.

If changes are made to this Program, the Member will be notified. Changes will apply to benefits for services received on or after the effective date unless otherwise required by applicable law.

The effective date is the *later* of:

- The effective date of the change;
- The Member's Effective Date of coverage; or
- The Group Contract anniversary date coinciding with or next following that service's effective date.

Please read this Benefit Booklet thoroughly and keep it handy. It will answer most questions regarding the Health Benefit Plan's procedures and services. **If Members have any questions, they should call the Customer Service Department ("Customer Service") at the telephone number shown on the Members Identification Card ("ID Card")**.

Any rights of a Member to receive benefits under the Group Contract and Benefit Booklet are personal to the Member and may not be assigned in whole or in part to any person, Provider or entity, nor may benefits be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under the Group Contract and Benefit Booklet, as required by law.

See ***Important Notices*** section for updated language and coverage changes that may affect this Benefit Booklet.

Your Costs	
Benefit Period	Contract Year (12 month period beginning on the Group's anniversary date).
Out-of-Pocket Maximum	
Per Member	$6,350
Per Family	$12,700
The Out-of-Pocket Maximum is the maximum dollar amount that a Member pays for Covered Services within a Benefit Period. The Out-of-Pocket Maximum includes Copayments, Deductibles, and Coinsurance amounts; it does not include the amount for any services not covered under this Contract and Benefit Booklet.	
Lifetime Benefit Maximum	Unlimited
Coinsurance is a percentage of the Covered Service that must be paid by the Member. Coinsurance is applied to some of the Covered Services listed below, but not to Covered Services that require the Member to pay a Copayment amount.	
SCHEDULE OF COVERED SERVICES	
The Member is entitled to benefits for the Covered Services described in their Benefit Booklet, subject to any Coinsurance, Copayment or Limitations described below. If the Participating Provider's usual fee for a Covered Service is less than the Coinsurance or Copayment shown in this schedule, the Member is only responsible to pay the Participating Provider's usual fee. The Participating Provider is required to remit any Coinsurance or Copayment overpayment directly to the Member. Contact Customer Service at the phone number on the Member ID Card with any questions regarding this. The Member's Primary Care Physician or Specialist must obtain Preapproval from the Health Benefit Plan to confirm this Program's coverage for certain Covered Services. If the Member's Primary Care Physician or Specialist provides a Covered Service or Referral without obtaining the Health Benefit Plan's Preapproval, the Member is not responsible for payment for that Covered Service. The Member can access a complete list of services that require Preapproval, by logging onto www.ibx.com/My Benefits Information tab, or by calling Customer Service at the phone number listed on the Member ID Card to have the list mailed to them.	

BENEFIT	COST SHARING
Alcohol or Drug Abuse And Dependency Treatment[3] (Including Detoxification Services**)**	
Inpatient Alcohol Or Drug Abuse And Dependency Treatment Admissions	$500 Copayment per day, to a maximum of $2,500 per admission*
Outpatient Alcohol Or Drug Abuse And Dependency Treatment Visits/Sessions	$60 Copayment per service/occurrence
Ambulance Services[4]	
Emergency Services	$50 Copayment per service/occurrence
Non-Emergency Services	$50 Copayment per service/occurrence
Blood[3]	$60 Copayment per service/occurrence
Diabetic Education Program[4]	None

BENEFIT	COST SHARING
Note for Diabetic Education Program shown above: Copayments, Coinsurance and maximum amounts do not apply to this benefit.	
Diabetic Equipment And Supplies[4]	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
Diagnostic Services-Non-Routine [4] (including MRI/MRA, CT scans, PET scans)	$250 Copayment per visit
Sleep Studies[4]	
Sleep Center	$250 Copayment per service/ occurrence
Outpatient Hospital	$450 Copayment per service/ occurrence
Diagnostic Services – Routine[4]	$60 Copayment per visit
Durable Medical Equipment[4] (including Prosthetic Devices and Orthotics**)**	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
Emergency Services - Facility[4]	$250 Copayment per service/occurrence (not waived if admitted)
Note for the Emergency Services shown above: The emergency room cost share will be the PCP Office Visit Copayment if the Member notifies us that they were directed to the emergency room by their Primary Care Physician or the Health Benefit Plan, and the services could have been provided in their Primary Care Physician's office.	
Home Health Care[4]	$60 Copayment per service/occurrence
Note for Home Health Care shown above: Maximum of 60 visits per Benefit Period	
Hospice Services[3]	
Inpatient Hospice Service	None
Outpatient Hospice Services	
Professional Service	None
Facility Service for Respite Care	None
Note for Hospice Services shown above: Respite Care: Maximum of seven days every six months	
Hospital Services[2]	$500 Copayment per day, to a maximum of $2,500 per admission*
Professional Service	None
Immunizations[1]	None

BENEFIT	COST SHARING
Injectable Medications[4]	
Specialty Injectable Drugs	$125 Copayment per service/ occurrence
Standard Injectable Drugs	None
Laboratory and Pathology Tests[4]	None
Maternity/OB-GYN/Family Services[3]	
Artificial Insemination	$30 Copayment per service/occurrence
Elective Abortion	
Professional Service	$30 Copayment per day
Facility Service	$250 Copayment per day
Maternity/Obstetrical Care	
Professional Service	Single Copayment of $30
Facility Service	$500 Copayment per day, to a maximum of $2,500 per admission*
Newborn Care	None
Medical Care[2]	None
Medical Foods and Nutritional Formulas[4]	$60 Copayment per service/occurrence
Mental Health Care[3]	
Inpatient Mental Health Care Admissions	$500 Copayment per day, to a maximum of $2,500 per admission*
Outpatient Mental Health Care Visits/Sessions	$60 Copayment per service/occurrence
Inpatient Serious Mental Health Care Admissions	$500 Copayment per day, to a maximum of $2,500 per admission*
Outpatient Serious Mental Health Care Visits/Sessions	$60 Copayment per service/occurrence
Non-Surgical Dental[4]	$60 Copayment per service/occurrence
Nutrition Counseling For Weight Management[1]	None
Note for Nutrition Counseling For Weight Management shown above: Benefit Period maximum: 6 visits/sessions	

BENEFIT	COST SHARING
Prescription Drugs[4]	
Participating Pharmacy	
Generic Formulary Drug	$10 Copayment per Prescription+
Brand Formulary Drug	$50 Copayment per Prescription
Non-Formulary Drug	$75 Copayment per Prescription
Participating Mail Service Pharmacy	
The amount of your cost sharing is determined by the days-supply the Member receives of Covered Maintenance Drugs.	
Generic Formulary Drug (1-30 day supply)	$10 Copayment per Prescription+
Brand Formulary Drug (1-30 day supply)	$50 Copayment per Prescription
Non-Formulary Drug (1-30 day supply)	$75 Copayment per Prescription
Generic Formulary Drug (31-90 day supply)	$20 Copayment per Prescription++
Brand Formulary Drug (31-90 day supply)	$100 Copayment per Prescription
Non-Formulary Drug (31-90 day supply)	$150 Copayment per Prescription
+ Certain generic drugs are covered at $4.	
++ Certain generic drugs are covered at $8.	

Prescription Drug Limitations

A description of limitations for your Covered Drugs Or Supplies is described below:

- A pharmacy need not dispense a Prescription Order Or Refill which, in the Pharmacist's professional judgment, should not be filled, without first consulting with the prescribing physician.
- The quantity of a Covered Prescription Drug dispensed per Prescription Drug Copay from a pharmacy pursuant to a Prescription Order Or Refill is limited to 30 consecutive days or the maximum allowed dosage as prescribed by law, whichever is less.
  Up to a 90 day supply of a Covered Maintenance Prescription Drug may be obtained through a Participating Mail Service Pharmacy for two times the Prescription Drug cost sharing.
- Prescription Refills will not be provided beyond six months from the most recent dispensing date.
- Prescription Refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage Prescribed.
- The Member must present their ID Card, and the existence of Prescription Drug Coverage must be indicated on the card.
- The member will pay to a Participating Pharmacy
  - One 100% of the cost for a Prescription Drug dispensed when the Member fails to show their ID Card. A claim for reimbursement for Covered Drugs Or Supplies may be submitted to the Health Benefit Plan;
  - One hundred percent (100%) of a non-Covered Drug Or Supply; or
  - The Prescription Drug cost sharing as specified in this schedule.

BENEFIT	COST SHARING
Prescription Drug Limitations (continued) • In certain cases the Health Benefit Plan may determine that the use of a certain Covered Drug Or Supply for a Member's medical condition requires Preapproval for Medical Necessity. • The Health Benefit Plan reserves the right to apply eligible dispensing limits for certain Covered Prescription Drugs as conveyed by the FDA or the Health Benefit Plan's Pharmacy and Therapeutics Committee.	
Note for Prescription Drug shown above: **Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% for generic products and for those methods that do not have a generic equivalent. Brand contraceptive products with a generic equivalent are covered as reflected under the Brand Name Drug cost share in this *Schedule of Covered Services*.**	
Preventive Care – Adult(1)	None
Preventive Care – Pediatric(1)	None
Primary Care Physician Office Visits - Non-Preventive(1) (Includes Home Visits, Retail Clinic Visits, and Outpatient Consultations)	$30 Copayment per service/ occurrence
Skilled Nursing Facility Services(2)	$250 Copayment per day, to a maximum of $1,250 per admission
Note for Skilled Nursing Facility Services shown above: Benefit Period Maximum: 120 Inpatient days	
Specialist Office Visits(4)	$60 Copayment per service/occurrence
Spinal Manipulation Services(4)	$60 Copayment per provider per service/occurrence
Note for Spinal Manipulation Services shown above: Benefit Period maximum: 20 visits	
Surgical Services(3)	
Outpatient Ambulatory Facility Service	$250 Copayment per day
Outpatient Hospital Facility Service	$450 Copayment per day
Outpatient Anesthesia	None
Outpatient Professional Services	None
Second Surgical Opinion (Voluntary)	$60 Copayment per opinion
Note for Surgical Services shown above: If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Health Benefit Plan will pay 100% of the contracted fee schedule amount, less any required Member Copayments for the highest paying procedure and 50% of the contracted fee schedule amount for each additional procedure.	

BENEFIT	COST SHARING
Therapy Services (Rehabilitative and Habilitative Services)[4]	
Cardiac Rehabilitation Therapy	$60 Copayment per provider per date of service
Note for Cardiac Rehabilitation Therapy shown above: Benefit Period maximum: 36 sessions	
Chemotherapy	$60 Copayment per provider per date of service
Dialysis	$60 Copayment per provider per date of service
Infusion Therapy	$60 Copayment per provider per date of service
Physical Therapy/Occupational Therapy	$60 Copayment per provider per date of service
Note for Physical Therapy/Occupational Therapy shown above: Benefit Period maximum: 30 sessions Benefit Period maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.	
Respiratory/Pulmonary Rehabilitation Therapy	$60 Copayment per provider per date of service
Note for Respiratory/Pulmonary Rehabilitation Therapy shown above: Benefit Period maximum: 36 sessions	
Radiation Therapy	$60 Copayment per provider per date of service
Speech Therapy	$60 Copayment per provider per date of service
Note for Speech Therapy shown above: Benefit Period maximum: 30 sessions	
Transplant Services[3]	Applicable Inpatient or Outpatient Facility or Professional Provider Copayments or Coinsurance will apply
Urgent Care Centers[4]	$87 Copayment per service/occurrence

BENEFIT	COST SHARING
Vision Care - Adult[4]	
Participating Provider	
Routine Eye Exam & Refraction (Once every calendar year)	None
Frames and Prescription Lenses (Once every calendar year)	$100 Reimbursement amount
Benefits are provided for prescription contact lenses in lieu of eyeglasses for up to $100 for every one calendar year.	
Non-Participating Provider	Not Covered
Vision Care - Pediatric[4]	
Participating Provider	
Routine Eye Exam & Refraction (Once every calendar year)	None
Frames and Prescription Lenses (Once every calendar year)	None
Non-Participating Provider	Not Covered
Women's Preventive Care[1]	None
Inpatient Copayment Waiver Provision	
* If an inpatient Copayment is shown in this schedule, it applies to each admission, readmission or transfer of a Member for Covered Services for Inpatient treatment of any condition. For purposes of calculating the total Copayment due, any admission occurring within ten days of discharge from any previous admission shall be treated as part of the previous admission.	

(1) Located in the Primary & Preventive Care Section of the ***Description of Covered Services***
(2) Located in the Inpatient Section of the ***Description of Covered Services***
(3) Located in the Inpatient/Outpatient Section of the ***Description of Covered Services***
(4) Located in the Outpatient Section of the ***Description of Covered Services***

BENEFIT

Dental (Pediatric)[4]

The Member must select a Primary Dental Office (PDO) to receive Covered Services. The Member's PDO will perform the below procedures or refer the Member to a Specialty Care Dentist for further care. Treatment by an Out-of-Network Dentist is not covered, except as described in the Contract and Benefit Booklet.

Only procedures listed in this ***Schedule of Covered Services*** are Covered Services. For services not listed (not covered), the Member is responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.

For a complete description of the Member's Pediatric Dental Covered Services, please refer to the Contract and Benefit Booklet in addition to this ***Schedule of Covered Services***.

Waiting Period: Benefits for the diagnosis or treatment of Orthodontia services will be eligible **12 months** after the effective date of the Member's coverage.

ADA Code	ADA Description	Copayment
	Clinical Oral Evaluations	
D0120	Periodic oral evaluation - established patient	0
D0140	Limited oral evaluation - problem focused	0
D0150	Comprehensive oral evaluation - new or established patient	0
D0160	Detailed and extensive oral evaluation - Problem focused, by report	0
D0180	Comprehensive periodontal evaluation - new or established patient	0
	Radiographs/Diagnostic Imaging (including interpretation)	
D0210	Intraoral - complete series of radiographic images	0
D0220	Intraoral - periapical first radiographic image	0
D0230	Intraoral - periapical each additional radiographic image	0
D0240	Intraoral - occlusal radiographic image	0
D0270	Bitewing - single radiographic image	0
D0272	Bitewings - two radiographic images	0
D0274	Bitewings - four radiographic images	0
D0277	Vertical bitewings - 7 to 8 radiographic images	0
D0330	Panoramic radiographic image	0
D0340	Cephalometric radiographic image	0
D0350	Oral/facial photographic images obtained intraorally or extraorally	25
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	25
	Tests and Examinations	
D0470	Diagnostic casts	0

ADA Code	ADA Description	Copayment
	Oral Pathology Laboratory	
D0601	Caries risk assessment and documentation, with a finding of low risk	0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0
D0603	Caries risk assessment and documentation, with a finding of high risk	0
	Dental Prophylaxis	
D1110	Prophylaxis - adult	0
D1120	Prophylaxis - child	0
	Topical Fluoride Treatment (office procedure)	
D1206	Topical application of fluoride varnish	0
D1208	Topical application of fluoride	0
	Other Preventive Services	
D1351	Sealant - per tooth	8
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	10
	Space Maintenance (passive appliances)	
D1510	Space maintainer - fixed - unilateral	42
D1515	Space maintainer - fixed - bilateral	64
D1520	Space maintainer - removable - unilateral	55
D1525	Space maintainer - removable - bilateral	72
D1550	Re-cementation of space maintainer	10
	Amalgam Restorations (including polishing)	
D2140	Amalgam - one surface, primary or permanent	13
D2150	Amalgam - two surfaces, primary or permanent	17
D2160	Amalgam - three surfaces, primary or permanent	19
D2161	Amalgam - four or more surfaces, primary or permanent	23
	Resin-Based Composite Restorations – Direct	
D2330	Resin-based composite - one surface, anterior	15
D2331	Resin-based composite - two surfaces, anterior	20
D2332	Resin-based composite - three surfaces, anterior	23
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	25
	Inlay/Onlay Restorations	
D2510	Inlay - metallic - one surface	236 ♦
D2520	Inlay - metallic - two surfaces	254 ♦

ADA Code	ADA Description	Copayment
	Inlay/Onlay Restorations (Continued)	
D2530	Inlay - metallic - three or more surfaces	279♦
D2542	Onlay - metallic - two surfaces	322♦
D2543	Onlay - metallic - three surfaces	342♦
D2544	Onlay - metallic - four or more surfaces	361♦
	Crowns - Single Restorations Only	
D2740	Crown - porcelain/ceramic substrate	341
D2750	Crown - porcelain fused to high noble metal	329♦
D2751	Crown - porcelain fused to predominantly base metal	294
D2752	Crown - porcelain fused to noble metal	316♦
D2780	Crown - 3/4 cast high noble metal	337♦
D2781	Crown - 3/4 cast predominantly base metal	337
D2783	Crown - 3/4 porcelain/ceramic	337
D2790	Crown - full cast high noble metal	321♦
D2791	Crown - full cast predominantly base metal	293
D2792	Crown - full cast noble metal	304♦
D2794	Crown - titanium	294
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	11
D2920	Recement crown	11
D2929	Prefabricated porcelain/ceramic crown - primary tooth	
D2930	Prefabricated stainless steel crown - primary tooth	30
D2931	Prefabricated stainless steel crown - permanent tooth	32
D2940	Protective restoration	0
D2949	Restorative foundation for an indirect restoration	0
D2950	Core buildup, including any pins, when required	36
D2951	Pin retention - per tooth, in addition to restoration	12
D2954	Prefabricated post and core in addition to crown	42
D2980	Crown repair necessitated by restorative material failure	35
D2981	Inlay repair necessitated by restorative material failure	35
D2982	Onlay repair necessitated by restorative material failure	35
D2983	Veneer repair necessitated by restorative material failure	35
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration)	17
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	17

ADA Code	ADA Description	Copayment
	Endodontic Therapy on Primary Teeth	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	26
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	32
	Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	75
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	90
D3330	Endodontic therapy, molar (excluding final restoration)	178
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy - anterior	69
D3347	Retreatment of previous root canal therapy - bicuspid	118
D3348	Retreatment of previous root canal therapy - molar	284
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	50
D3352	Apexification/recalcification - interm medication replacement	25
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	120
D3355	Pulpal regeneration - initial visit	50
D3356	Pulpal regeneration - interim medication replacement	25
D3357	Pulpal regeneration - completion of treatment	30
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy - anterior	114
D3421	Apicoectomy - bicuspid (first root)	183
D3425	Apicoectomy surgery - molar (first root)	196
D3426	Apicoectomy (each additional root)	69
D3427	Periradicular surgery without apicoectomy	196
D3450	Root amputation - per root	101
	Other Endodontic Procedures	
D3920	Hemisection (including any root removal), not including root canal therapy	84
	Surgical Services (including usual postoperative care)	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	82
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	37

ADA Code	ADA Description	Copayment
	Surgical Services (Continued) (including usual postoperative care)	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	105
D4249	Clinical crown lengthening - hard tissue	168
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	205
D4270	Pedicle soft tissue graft procedure	200
D4273	Subepithelial connective tissue graft procedures, per tooth	250
D4277	Free soft tissuse graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	250
D4278	Free soft tissuse graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in the same graft site	15
	Non-Surgical Periodontal Services	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	40
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	17
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	22
	Other Periodontal Services	
D4910	Periodontal maintenance	32
D4921	Gingival irrigation - per quadrant	25
	Complete Dentures (including routine post-delivery care)	
D5110	Complete denture - maxillary	343
D5120	Complete denture - mandibular	343
D5130	Immediate denture - maxillary	359
D5140	Immediate denture - mandibular	359
	Partial Dentures (including routine post-delivery care)	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	284
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	335
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	377

ADA Code	ADA Description	Copayment
	Partial Dentures (Continued) (including routine post-delivery care)	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	377
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	232
	Adjustments To Dentures	
D5410	Adjust complete denture - maxillary	10
D5411	Adjust complete denture - mandibular	10
D5421	Adjust partial denture - maxillary	11
D5422	Adjust partial denture - mandibular	11
	Repairs To Complete Dentures	
D5510	Repair broken complete denture base	19
D5520	Replace missing or broken teeth - complete denture (each tooth)	17
	Repairs To Partial Dentures	
D5610	Repair resin denture base	19
D5620	Repair cast framework	20
D5630	Repair or replace broken clasp	23
D5640	Replace broken teeth - per tooth	17
D5650	Add tooth to existing partial denture	20
D5660	Add clasp to existing partial denture	24
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	60
D5720	Rebase maxillary partial denture	58
D5721	Rebase mandibular partial denture	58
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	36
D5731	Reline complete mandibular denture (chairside)	36
D5740	Reline maxillary partial denture (chairside)	33
D5741	Reline mandibular partial denture (chairside)	33
D5750	Reline complete maxillary denture (laboratory)	51
D5751	Reline complete mandibular denture (laboratory)	51
D5760	Reline maxillary partial denture (laboratory)	49
D5761	Reline mandibular partial denture (laboratory)	48
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	33
D5851	Tissue conditioning, mandibular	33

ADA Code	ADA Description	Copayment
	Surgical Services	
D6010	Surgical placement of implant body: endosteal implant	1050
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	700
D6040	Surgical placement: endosteal implant	1050
D6050	Surgical placement: transosteal implant	1050
D6053	Implant/abutment supported removable denture for completely edentulous arch	980
D6054	Implant/abutment supported removable denture for partially edentulous arch	980
D6055	Connecting bar - implant supported or abutment supported	280
D6056	Prefabricated abutment - includes modification and placement	230
D6058	Abutment supported porcelain/ceramic crown	595
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	595
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	525
D6061	Abutment supported porcelain fused to metal crown (noble metal)	525
D6062	Abutment supported cast metal crown (high noble metal)	525
D6063	Abutment supported cast metal crown (predominantly base metal)	525
D6064	Abutment supported cast metal crown (noble metal)	525
D6065	Implant supported porcelain/ceramic crown	525
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	525
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	525
D6068	Abutment supported retainer for porcelain/ceramic FPD	525
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	525
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	525
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	525
D6072	Abutment supported retainer for cask fused to metal FPD (high noble metal)	525
D6073	Abutment supported retainer for cask fused to metal FPD (predominantly base metal)	525
D6074	Abutment supported retainer for cask fused to metal FPD (noble metal)	525
D6075	Implant supported retainer for ceramic FPD	525
D6076	Implant supported retainer for porcelain fused to metal FPD (titantium, titanium alloy or high noble metal)	525

ADA Code	ADA Description	Copayment
	Surgical Services (Continued)	
D6077	Implant supported retainer for cast metal FPD (titantium, titanium alloy or high noble metal)	525
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	55
D6090	Repair implant supported prothesis, by report	85
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prothesis, per attachment	125
D6095	Repair implant abutment, by report	70
D6100	Implant removal, by report	595
D6101	Debridement of periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	85
D6102	Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	120
D6103	Bone graft for repair of periimplant defect - not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration	180
D6104	Bone graft at time of implant placement	180
D6190	Radiographic/surgical implant index, by report	170
	Fixed Partial Denture Pontics	
D6210	Pontic - cast high noble metal	325♦
D6211	Pontic - cast predominantly base metal	298
D6212	Pontic - cast noble metal	312♦
D6214	Pontic - titanium	299
D6240	Pontic - porcelain fused to high noble metal	327♦
D6241	Pontic - porcelain fused to predominantly base metal	289
D6242	Pontic - porcelain fused to noble metal	315♦
D6245	Pontic - porcelain/ceramic	290
	Fixed Partial Denture Retainers - Inlays/Onlays	
D6545	Retainer - cast metal for resin bonded fixed prothesis	295
D6548	Retainer - porcelain/ceramic for resin bonded fixed prothesis	160
	Fixed Partial Denture Retainers - Crowns	
D6740	Crown - porcelain/ceramic	295
D6750	Crown - porcelain fused to high noble metal	329♦
D6751	Crown - porcelain fused to predominantly base metal	294
D6752	Crown - porcelain fused to noble metal	316♦
D6780	Crown - 3/4 cast high noble metal	321♦
D6781	Crown - 3/4 cast predominantly base metal	321
D6782	Crown - 3/4 cast noble metal	321♦

ADA Code	ADA Description	Copayment
	Fixed Partial Denture Retainers - Crowns (Continued)	
D6783	Crown - 3/4 porcelain/ceramic	321
D6790	Crown - full cast high noble metal	327♦
D6791	Crown - full cast predominantly base metal	292
D6792	Crown - full cast noble metal	319♦
	Other Fixed Partial Denture Services	
D6930	Recement fixed partial denture	30
D6980	Fixed partial denture repair, necessitated by restorative material failure	70
	Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	16
	Surgical Extractions (includes local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	51
D7220	Removal of impacted tooth - soft tissue	72
D7230	Removal of impacted tooth - partially bony	98
D7240	Removal of impacted tooth - completely bony	113
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	120
D7250	Surgical removal of residual tooth roots (cutting procedure)	53
D7251	Coronectomy - intentional partial tooth removal	113
	Other Surgical Procedures	
D7270	Tooth reimplantation and/or stablization of accidentally evulsed or displace tooth	150
D7280	Surgical access of an unerupted tooth	97
	Alveoloplasty (surgical preparation of ridge for dentures)	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	48
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	30
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	60
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	25

ADA Code	ADA Description	Copayment
	Vestibuloplasty	
D7471	Removal of lateral exostosis (maxilla or mandible)	210
D7510	Incision and drainage of abscess	45
	Other Repair Procedures	
D7910	Suture of recent wounds up to 5	150
D7921	Collection and application of autologous blood concentrate product	300
D7971	Excision of pericoronal gingiva	120
	Limited Orthodontic Treatment*	
D8010	Limited orthodontic treatment of the primary dentition	599
D8020	Limited orthodontic treatment of the transitional dentition	759
D8030	Limited orthodontic treatment of the adolescent dentition	1,071
	Interceptive Orthodontic Treatment*	
D8050	Interceptive orthodontic treatment of the primary dentition	885
D8060	Interceptive orthodontic treatment of the transitional dentition	1,309
	Comprehensive Orthodontic Treatment*	
D8070	Comprehensive orthodontic treatment of the transitional dentition	3,190
D8080	Comprehensive orthodontic treatment of the adolescent dentition	3,454
	Minor Treatment To Control Harmful Habits*	
D8210	Removable appliance therapy	433
D8220	Fixed appliance therapy	537
	Other Orthodontic Services*	
D8660	Pre-orthodontic treatment visit	250
D8670	Periodic orthodontic treatment visit (as part of contract)	130
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	343
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	0
	Anesthesia	
D9220	Deep sedation/general anesthesia - first 30 minutes	150
D9221	Deep sedation/general anesthesia – each additional 15 minutes	155
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	150
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	155

ADA Code	ADA Description	Copayment
	Professional Consultation	
D9310	Consultation - diagnostic service provided by dentist or Physician other than requesting dentist or Physician	19
	Drugs	
D9610	Theraputic parenteral drug, single administration	35
	Miscellaneous Services	
D9930	Treatment of complications (post surgical) - unusual circumstances, by report	80
D9940	Occlusal guard, by report	260
★	Broken appointment per 15 minutes (without 24-hour notice)	15

Footnotes

* See "Orthodontic Coverage" contained in the "Dental (Pediatric)" section of the ***Description of Covered Services***.

★ Please report under code D9999 "Unspecified adjunctive procedure, by report."

♦ Charges for the use of precious (high noble) or semiprecious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional $125 for these materials.

Pediatric Dental Limitations[(4)]

The following services, **if listed above**, will be subject to limitations as set forth below:

- Bitewing x-rays – one set per six consecutive months.
- Panoramic or full mouth x-rays – one per three-year period.
- Prophylaxis – one per six consecutive month period.
- Routine prophylaxis is limited to no more than one per six consecutive month period and periodontal maintenance procedures are limited to four per 12 consecutive month period.
- Sealants – one per tooth per three years on permanent first and second molars.
- Fluoride treatment – one per six consecutive months through age 18.
- Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.
- Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.
- Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five- year period.
- Crown lengthening – one per tooth per lifetime.
- Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.
- Coverage for referral to a pediatric Specialty Care Dentist ends on a Member’s seventh birthday.
- Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.
- Root canal treatment – one per tooth per lifetime.
- Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.

Pediatric Dental Limitations[4]
(Continued)

- Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.
- Full and partial dentures – one per arch in a five- year period.
- Denture relining, rebasing or adjustments – are included in the denture charges if provided within six (6) months of insertion by the same dentist.
- Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.
- Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25 cm, frenectomy and crown lengthening.
- Wisdom teeth (third molars) extracted for Members under age 15 are not eligible for payment in the absence of specific pathology.
- If for any reason orthodontic services are terminated or coverage under the Program is terminated before completion of the approved orthodontic treatment, the responsibility of the Health Benefit Plan will cease with payment through the month of termination.
- Orthodontic treatment – not eligible for Members over age 18.
- Comprehensive orthodontic treatment plan – one per lifetime.
- In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Program covers necessary diagnostic and therapeutic dental procedures administered by and Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of $50 for each emergency visit.
- Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).
- An Alternate Benefit Provision (ABP) may be applied by the Primary Dental Office if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.

(4) Located in the Outpatient Section of the ***Description of Covered Services***

DESCRIPTION OF COVERED SERVICES

Subject to the Exclusions, conditions and Limitations of this Program, a Member is entitled to benefits for the Covered Services described in this ***Description of Covered Services*** section. The Member may be responsible for applicable cost sharing or there may be limits on services as specified in the ***Schedule of Covered Services*** section of the Benefit Booklet. Additional benefits may be provided by the Group through the addition of a Rider. If applicable, this benefit information is also included with this Benefit Booklet. Please take time to read this ***Description of Covered Services*** and the ***Schedule of Covered Services***, and use them as references whenever services are required.

More detailed information on eligibility, terms and conditions of coverage, and contractual responsibilities is contained in the Group's Contract with the Health Benefit Plan. This is available through the Group benefits administrator.

Most Covered Services are provided or arranged by the Member's Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services that the Member needs, a Referral to a Non-Participating Provider will be arranged by the Member's Primary Care Physician, with approval by the Health Benefit Plan. See ***Access to Primary, Specialist, And Hospital Care*** in the ***General Information*** section for procedures for obtaining Preapproval for use of a Non-Participating Provider.

Some Covered Services must be Preapproved before the Member can receive the services. The Primary Care Physician or Referred Specialist must seek the Health Benefit Plan's approval and confirm that coverage is provided for certain services. Preapproval of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Preapproval helps determine whether a different treatment may be available that is equally effective yet less traumatic. Preapproval also helps determine the most appropriate setting for certain services.

If a Primary Care Physician or Referred Specialist provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment to access a complete list of services that require Preapproval, log onto www.ibx.com or the Member can call Customer Service at the phone number listed on the Member's ID Card to have the list mailed to the Member.

If the Member should have questions about any information in this Benefit Booklet or need assistance at any time, please feel free to contact Customer Service by calling the telephone number shown on the Member's ID Card.

PRIMARY AND PREVENTIVE CARE

The Member is entitled to benefits and Primary and Preventive Care Covered Services when:

- The Member's Primary Care Physician (PCP) either provides or arranges for these Covered Services, as noted.
- The Member's Primary Care Physician (PCP) provides a Referral, when one is required, to a Participating Professional Provider when their condition requires a Specialist's Services

If the Member receives services that result from a Referral to a Non-Participating Provider, the following will apply:

- They will be covered, when the Referral is issued by the Member's Primary Care Physician

and Preapproved by the Health Benefit Plan.
- The Referral will be valid for 90 days from the date it was issued. This is the case, so long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider, contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Health Benefit Plan about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:
- This will require yet another electronic referral from the Member's Primary Care Physician.

- **Self-Referrals are excluded, except for Emergency Services or if covered by a Rider.** The only time the Member can refer their self is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Member has no symptoms of disease.
"Primary Care" services generally describe health care services performed to treat an illness or injury.

The Health Benefit Plan reviews the ***Schedule of Covered Services***, at certain times. Reviews are based on recommendations from organizations such as:
- The American Academy of Pediatrics;
- The American College of Physicians;
- The U.S. Preventive Services Task Force; and
- The American Cancer Society.

Accordingly, the frequency and eligibility of Covered Services are subject to change.

The Health Benefit Plan reserves the right to modify this Program for these Covered Services at any time. However, the Member has to be given a written notice of the change, before the change takes effect.

Immunizations

The Health Benefit Plan will provide coverage for the following:
- Pediatric Immunizations;
- Adult Immunizations; and
- The agents used for the Immunizations.

All immunizations and the agents must conform to the standards of the *Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services*.

Pediatric and adult Immunization ACIP schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/recs/schedules/default.htm

The benefits for these pediatric immunizations are limited to Members under 21 years of age.

Nutrition Counseling for Weight Management

The Health Benefit Plan will provide coverage for nutrition counseling visits or sessions for the purpose of weight management. However, they need to be performed and billed by any of the following Providers, in an office setting:

- By the Member's Physician;
- By a Referred Specialist; or
- By a Registered Dietitian (RD).

This benefit is in addition to any other nutrition counseling Covered Services described in this Benefit Booklet. The Member does not need a Referral from their Primary Care Physician to obtain services for Nutrition Counseling for Weight Management.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

The Health Benefit Plan will provide coverage for Bone Mineral Density Testing (BMDT). The method used needs to be one that is approved by the U.S. Food and Drug Administration. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which depends on both bone density and bone quality. Bone quality refers to how the bone is built, architecture, turnover and mineralization of bone.

The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

Preventive Care - Adult

Adult Preventive Care includes the following:

- Physical Examination, Routine History. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Members 18 years of age or older.
- Blood Cholesterol Test. This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.
- Complete Blood Count (CBC). This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.
- Fecal Occult Blood Test. This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.
- Flexible Sigmoidoscopy. This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.
- Prostate Specific Antigen (PSA). This blood test may be used to detect tumors of the prostate.
- Routine Colonoscopy. This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.
- Barium enema screening.
- Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies.
- Thyroid Function Test. This test detects hyperthyroidism and hypothyroidism.
- Urinalysis. This test detects numerous abnormalities.
- Fasting Blood Glucose Test. This test is used for detection of diabetes.
- Abdominal Aortic Aneurysm screening. One test per lifetime is recommended for men with a smoking history.

Preventive Care - Pediatric

Pediatric Preventive Care includes the following:

- Physical Examination. Routine History, Routine Diagnostic Tests. Well baby care, which

generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Members under 18 years of age.
- Blood Lead Screening. This blood test detects elevated lead levels in the blood.
- Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells.
- Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies.
- Urinalysis. This test detects numerous abnormalities.

Primary Care Physician Office Visits/Retail Clinics

The Health Benefit Plan will provide coverage for Medical Care visits, by a Primary Care Physician, for any of the following services:
- The examination of an illness or injury;
- The diagnosis of an illness or injury;
- The treatment of an illness or injury;

For the purpose of this benefit, "Office Visits" include:
- Medical Care visits to a Primary Care Physician's office;
- Medical Care visits to a Member's residence;
- Medical Care consultations on an Outpatient basis;
- Medical Care visits to the Member's Primary Care Physician's office, during and after regular office hours; or
- Emergency visits and visits to a Member's residence, if within the Service Area.

In addition to Office Visits a Member may receive Medical Care at a Retail Clinic. Retail Clinics are staffed by certified family nurse practitioners, who are trained to diagnose, treat, and write Prescriptions when clinically appropriate. Nurse practitioners are supported by a local Physician who is on-call during clinic hours to provide guidance and direction when necessary.

Examples of treatment and services that are provided at a Retail Clinic include, but are not limited to:
- Sore throat;
- Ear, eye, or sinus infection;
- Allergies;
- Minor burns;
- Skin infections or rashes; and
- Pregnancy testing.

Women's Preventive Care

Women's Preventive Care includes services and supplies as described under the Women's Preventive Services provision of the Patient Protection and Affordable Care Act. Covered Services and Supplies include, but are not limited to, the following:
- Routine Gynecological Exam, Pap Smear. Female Members are covered for one (1) routine gynecological exam each Benefit Period. This includes the following:
  - A pelvic exam and clinical breast exam; and
  - Routine Pap smears.

  These must be done in accordance with the recommendations of the *American College of Obstetricians and Gynecologists.*

  Female Members have direct access to care by a participating obstetrician or gynecologist. This means the Member does not need a referral, from the Member's Primary Care Physician, to receive this care**.**

- Mammograms. Coverage will be provided for screening and diagnostic mammograms without Referral.
  The Health Benefit Plan will only provide benefits for mammography if the following applies:
  - It is performed by a qualified mammography service Provider.
  - It is performed by a Participating Provider who is properly certified by the appropriate state or federal agency.
  - That certification is done in accordance with the Mammography Quality Assurance Act of 1992.
- Breastfeeding comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with Medical Necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member.
- Contraception: Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the Member. Contraception drugs and devices are covered under this Program unless otherwise covered under the Prescription Drug benefit issued with this Program.

INPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Inpatient Care are Covered Services when they are:
- Deemed Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preapproved by the Health Benefit Plan.

If the Member receives services that result from a Referral to a Non-Participating Provider, the following will apply:
- They will be covered, when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Health Benefit Plan.
- The Referral will be valid for 90 days from the date it was issued. This is the case, so long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider, contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Health Benefit Plan about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:
- This will require yet another electronic referral from the Member's Primary Care Physician.

Self Referrals are excluded, except for Emergency Services or if covered by a Rider. The only time the Member can refer their self is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

HOSPITAL SERVICES

- Ancillary Services
  The Health Benefit Plan will provide coverage for all ancillary services usually provided and billed for by Hospitals, except for personal convenience items. This includes, but is not limited to:
  - Meals, including special meals or dietary services, as required by the Member's

condition;
- Use of operating room, delivery room, recovery room, or other specialty service rooms and any equipment or supplies in those rooms;
- Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
- Oxygen and oxygen therapy;
- Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
- Therapy Services (Rehabilitative and Habilitative Services) when administered by a person who is appropriately licensed and authorized to perform such services;
- All drugs and medications (including intravenous injections and solutions);
  - For use while in the Hospital;
  - Which are released for general use; and
  - Which are commercially available to Hospitals.

  (The Health Benefit Plan reserves the right to apply quantity level limits as conveyed by the FDA or the Health Benefit Plan's Pharmacy and Therapeutics Committee for certain Prescription Drugs.)
- Use of special care units, including, but not limited to intensive care units or coronary care units; and
- Pre-admission testing.

- Room and Board

  The Health Benefit Plan will provide coverage for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:
  - An average semi-private room, as designated by the Hospital; or a private room, when designated by the Health Benefit Plan as semi-private for the purposes of this Program in Hospitals having primarily private rooms;
  - A private room, when Medically Necessary;
  - A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
  - A bed in a general ward; and
  - Nursery facilities.

Medical Care

The Health Benefit Plan will provide coverage for Medical Care rendered to the Member, in the following way, except as specifically provided.

It is Medical Care that is rendered:
- By a Participating Professional Provider who is in charge of the case;
- While the Member is an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility; and
- For a condition not related to Surgery, pregnancy, or Mental Illness.

Such care includes Inpatient intensive Medical Care rendered to the Member:
- While the Member's condition requires a Referred Specialist constant attendance and treatment; and
- For a prolonged period of time.

- Concurrent Care
  The Health Benefit Plan will provide coverage for the following services, while the Member is an Inpatient when they occur together:
  - Services rendered to the Member by a Referred Specialist:
    - Who is not in charge of the case; but
    - Whose particular skills are required for the treatment of complicated conditions.
  - Services rendered to the Member in a Participating Facility Provider as an Inpatient in a:
    - Hospital;
    - Rehabilitation Hospital; or
    - Skilled Nursing Facility.

  This does not include:
  - Observation or reassurance of the Member;
  - Standby services;
  - Routine preoperative physical examinations;
  - Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods; or
  - Medical Care required by a Participating Facility Provider's rules and regulations.

- Consultations
  The Health Benefit Plan will provide coverage for Consultation services when rendered in a Participating Facility Provider in both of the following ways:
  - By a Referred Specialist, at the request of the attending Participating Professional Provider; and
  - While the Member is an Inpatient in a:
    - Hospital;
    - Rehabilitation Hospital; or
    - Skilled Nursing Facility.

  Consultations do not include staff consultations which are required by the Participating Facility Provider's rules and regulations.

Skilled Nursing Facility

The Health Benefit Plan will provide coverage for a Participating Skilled Nursing Facility:
- When Medically Necessary as determined by this Health Benefit Plan
- When the Member requires treatment by skilled nursing personnel which can be provided:
  - Only on an Inpatient basis; and
  - Only in a Skilled Nursing Facility.
- As long as the services are not considered Custodial or Domiciliary Care. Benefits are limited to semi-private accommodations (or an allowance equal to this rate which may be applied to private accommodations).

During the Member's admission, members of the Health Benefit Plan's Care Management and Coordination team are monitoring the Member's stay.

They do this to:
- Assure that a plan for the Member's discharge is in place; and
- Make sure that the Member has a smooth transition from the facility to home or other setting.

- A case manager will work closely with the Member's Primary Care Physician, or the Referred Specialist to help with the Member's discharge. If necessary, they will arrange for other medical services, as well.

Should the Member's Primary Care Physician, or Referred Specialist, agree with the Health Benefit Plan that continued stay in a Skilled Nursing Facility is no longer required:
- The Member will be notified in writing of this decision.
- Should the Member decide to remain in the facility after its notification, the facility has the right to bill the Member after the date of the notification.
- The Member may appeal this decision through the Grievance appeal process.

INPATIENT/OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Inpatient or Outpatient Care are Covered Services when they are:
- Deemed Medically Necessary ;
- Provided or Referred by the Member's Primary Care Physician; and
- Preapproved by the Health Benefit Plan.

If the Member receives services that result from a Referral to a Non-Participating Provider:
- They will be covered when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Health Benefit Plan.
- The Referral is valid for 90 days from the date it was issued. This is the case, as long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Health Benefit Plan about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:
- This will require yet another electronic referral from your Primary Care Physician.

- **Self-Referrals are excluded, except for Emergency Services or if covered by a Rider**. The only time the Member can refer their self is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

Blood

The Health Benefit Plan will provide coverage for the administration of blood and blood processing from donors. In addition, benefits are also provided for:
- Autologous blood drawing, storage or transfusion.
  - This refers to a process that allows the Member to have their own blood drawn and stored for personal use.
  - One example would be self-donation, in advance of planned Surgery.
- Whole blood, blood plasma and blood derivatives:
  - Which are not classified as Prescription Drugs in the official formularies; and
  - Which have not been replaced by a donor.

Hospice Services

The Health Benefit Plan will provide coverage for palliative and supportive services to a terminally ill Member through a Hospice program by a Participating Hospice Provider.

- Who is eligible: The Member will be eligible for Hospice benefits if both of the following occur:
  - The Member's attending Primary Care Physician or Referred Specialist certifies that the Member has a terminal illness, with a medical prognosis of six months or less.
  - The Member elects to receive care primarily to relieve pain.
- The goal of care and what is included: Hospice Care provides services to make the Member as comfortable and pain-free as possible. This is primarily comfort care, and it includes:
  - Pain relief;
  - Physical care;
  - Counseling; and
  - Other services, that would help the Member cope with a terminal illness, rather than cure it.
- What happens to the treatment of the Member's illness: When the Member elects to receive Hospice Care:
  - Benefits for treatment provided to cure the terminal illness are no longer provided.
  - The Member can also change their mind and elect to not receive Hospice Care anymore.
- How long Hospice care continues: Benefits for Covered Hospice Services shall be provided until whichever occurs first:
  - The Member's discharge from Hospice Care; or
  - The Member's death.
- Respite Care for the Caregiver: If the Member were to receive Hospice Care primarily in the home, the Member's primary caregiver may need to be relieved, for a short period. In such a case, the Health Benefit Plan will provide coverage for the Member to receive the same kind of care in the following way:
  - On a short-term basis;
  - As an Inpatient; and
  - In a Medicare certified Skilled Nursing Facility.

  This can only be arranged when the Hospice considers such care necessary to relieve primary caregivers in the Member's home.

Maternity/Ob-Gyn/Family Services

- Artificial Insemination
  Facility services provided by a Participating Facility Provider and services performed by a Referred Specialist for the promotion of fertilization of a female recipient's own ova (eggs):
  - By the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying:
    - Simple sperm preparation;
    - Sperm washing; and/or
    - Thawing.

- Elective Abortions
  The Health Benefit Plan will provide coverage for services provided in a Participating Facility Provider that is a Hospital or Birth Center. It also includes services performed by a Referred Specialist for the voluntary termination of a pregnancy by a Member.

- Maternity/Obstetrical Care
  The Health Benefit Plan will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.
  - Pre-notification -The Health Benefit Plan should be notified of the need for maternity care within one month of the first prenatal visit to the Physician or midwife.
  - Facility and Professional Services - The Health Benefit Plan will provide coverage:
    - Facility services: Provided by Participating Facility Provider that is a Hospital or Birth Center; and
    - Professional services: Performed by a Referred Specialist or certified nurse midwife;
    - The Health Benefit Plan will provide coverage for certain services provided by a Referred Specialist for elective home births.
  - Scope of Care - The Health Benefit Plan will provide coverage for:
    - Prenatal care;
    - Postnatal care; and
    - Complications of pregnancy and childbirth.
  - Type of delivery - Maternity care Inpatient benefits will be provided for:
    - 48 hours for vaginal deliveries; and
    - 96 hours for cesarean deliveries.
  - Home Health Care for Early Discharge: In the event of early post-partum discharge from an Inpatient Admission:
    - Benefits are provided for Home Health Care, as provided for in the Home Health Care benefit.

- Newborn Care
  - A Member's newborn child will be entitled to benefits provided by this Program:
    - From the date of birth up to a maximum of 31 days
  - Such coverage within the 31 days will include care which is necessary for the treatment of:
    - Medically diagnosed congenital defects;
    - Medically diagnosed birth abnormalities;
    - Medically diagnosed prematurity; and
    - Routine nursery care.
  - Coverage for a newborn may be continued beyond 31 days under conditions specified in the ***General Information*** section of this Benefit Booklet.

Mental Health Care and Serious Mental Illness Health Care

The Health Benefit Plan will provide coverage for the treatment of Mental Health Care and Serious Mental Illness Health Care based on the services provided and reported by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

- Regarding a non-mental health provider who renders non-mental health care: When a Participating Professional Provider other than a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider, renders Medical Care to the Member other than Mental Health Care or Serious Mental Illness Health Care:
  - Coverage for such Medical Care will be based on the medical benefits available as shown in the ***Schedule of Covered Services*** included with this Benefit Booklet.
- A Referral from the Member's Primary Care Physician is not required to obtain Inpatient or Outpatient Mental Health Care or Serious Mental Illness Health Care. Instead:
  - Contact the Member's Primary Care Physician; or
  - Call the Mental Health phone number shown on the Member's ID card.

- Inpatient Mental Health Care and Serious Mental Illness Health Care: Benefits are provided for Covered Services during an Inpatient Mental Health Care or Serious Mental Illness Health Care admission for the treatment of a Mental Illness, including a Serious Mental Illness provided by a Participating Behavioral Health/Alcohol or Drug Abuse and Dependency. Inpatient Care Covered Services include treatments such as:
  - Psychiatric visits;
  - Psychiatric consultations;
  - Individual and group psychotherapy;
  - Electroconvulsive therapy;
  - Psychological testing; and
  - Psychopharmacologic management.
- Outpatient Mental Health Care and Serious Mental Illness Health Care: The Health Benefit Plan will provide coverage for Covered Services during an Outpatient Mental Health Care or Serious Mental Illness Health Care visit for:
  - The treatment of a Mental Illness, including a Serious Mental Illness; and
  - Provided by a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

  Outpatient Care Covered Services include treatments such as:
  - Psychiatric visits;
  - Psychiatric consultations;
  - Individual and group psychotherapy;
  - Participating Licensed Clinical Social Worker visits;
  - Masters Prepared Therapist visits;
  - Electroconvulsive therapy;
  - Psychological testing; and
  - Psychopharmacologic management, and psychoanalysis.

All Intensive Outpatient Program and Partial Hospitalization services must be approved by the Health Benefit Plan.

Routine Patient Costs Associated With Qualifying Clinical Trials

- The Health Benefit Plan provides coverage for Routine Patient Costs Associated With Participation in a Qualifying Clinical Trial (see the ***Important Definitions*** section).
- To ensure coverage and appropriate claims processing, the Health Benefit Plan must be notified in advance of the Member's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Provider, and conducted in a Participating Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Participating Provider, and in a Participating Facility Provider, then, the Health Benefit Plan will consider the services by a Non-Participating Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see Important Definitions section) by the Health Benefit Plan.

Surgical Services

The Health Benefit Plan will provide coverage for surgical services provided:

- By a Participating Professional Provider, and/or a Participating Facility Provider;
- For the treatment of disease or injury.

Separate payment will not be made for:

- Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure.

Covered Services also include:

- Congenital Cleft Palate. The orthodontic treatment of congenital cleft palates:
  - That involve the maxillary arch (the part of the upper jaw that holds the teeth);
  - That is performed together with bone graft Surgery; and
  - That is performed to correct bony deficits that are present with extremely wide clefts affecting the alveolus.

- Mastectomy Care. The Health Benefit Plan will provide coverage for the following when performed after a mastectomy: Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to:
  - Augmentation;
  - Mammoplasty;
  - Reduction mammoplasty; and
  - Mastopexy.

  Coverage is also provided for:
  - The surgical procedure performed in connection with the initial and subsequent insertion or removal of Prosthetic Devices (either before or after Surgery) to replace the removed breast or portions of it;
  - The treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedemas is not subject to any benefit Maximum amounts that may apply to "Physical Therapy" services as provided under the subsection entitled "Therapy Services (Rehabilitative and Habilitative Services)" of this section; and
  - Routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

- Anesthesia
  The Health Benefit Plan will provide coverage for the administration of Anesthesia:
  - In connection with the performance of Covered Services; and
  - When rendered by or under the direct supervision of a Referred Specialist other than the surgeon, assistant surgeon or attending Referred Specialist.

- Assistant at Surgery
  The Health Benefit Plan will provide coverage for an assistant surgeon's services if:
  - The assistant surgeon actively assists the operating surgeon in the performance of covered Surgery;
  - An intern, resident, or house staff member is not available; and
  - The Member's condition or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Health Benefit Plan.

- Hospital Admission for Dental Procedures or Dental Surgery.
  The Health Benefit Plan will provide coverage for a Hospital admission in connection with dental procedures or Surgery only when:
  - The Member has an existing non-dental physical disorder or condition; and
  - Hospitalization is Medically Necessary to ensure the Member's health.

  Dental procedures or Surgery performed during such a confinement will only be covered for the services described in "Oral Surgery" and "Assistant at Surgery" provisions.

- Oral Surgery
  The Health Benefit Plan will provide coverage for oral Surgery is subject to special conditions as described below:
  - Orthognathic Surgery – Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
    - For accidents: The initial treatment of Accidental Injury/trauma (That is, fractured facial bones and fractured jaws), in order to restore proper function.

- For congenital defects**:** In cases where it is documented that a severe congenital defect (That is, cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
- For chewing and breathing problems: In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic Surgery will decrease airway resistance, improve breathing, or restore swallowing.

– Other Oral Surgery – Defined as Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered Service will only be provided for:
- Surgical removal of impacted teeth which are partially or completely covered by bone;
- Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
- Surgical removal of teeth prior to cardiac Surgery, Radiation Therapy or organ transplantation.

- Second Surgical Opinion (Voluntary)
  The Health Benefit Plan will provide coverage for consultations for Surgery to determine the Medical Necessity of an elective surgical procedure.
  – "Elective Surgery" is that Surgery which is not of an Emergency or life threatening nature.
  – Such Covered Services must be performed and billed by a Referred Specialist other than the one who initially recommended performing the Surgery.

Transplant Services

When the Member is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Covered Services. Covered Services for Inpatient and Outpatient Care related to the transplant include procedures which are generally accepted as not Experimental/Investigational Services by medical organizations of national reputation. These organizations are recognized by the Health Benefit Plan as having special expertise in the area of medical practice involving transplant procedures. Benefits are also provided for those services which are directly and specifically related to the Member's covered transplant. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of blood provided to the Member.

The determination of Medical Necessity for transplants will take into account the proposed procedure's suitability for the potential recipient and the availability of an appropriate facility for performing the procedure.

Eligibility for Covered Services related to human organ, bone and tissue transplant are as follows.

If a human organ or tissue transplant is provided by a donor to a human transplant recipient:
- When both the recipient and the donor are Members, each is entitled to the benefits of this Program
- When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of the Benefit Booklet. However, donor benefits are limited to only those not

provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.

- When only the donor is a Member, the donor is entitled to the benefits of the Benefit Booklet, subject to following additional limitations:
  - The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of the Benefit Booklet; and
  - No benefits will be provided to the non-Member transplant recipient.
- If any organ or tissue is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered. Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program. Covered Services of a donor include:
  - Removal of the organ;
  - Preparatory pathologic and medical examinations; and
  - Post-surgical care.

Treatment for Alcohol Or Drug Abuse and Dependency

- Alcohol Or Drug Abuse And Dependency is a disease that can be described as follows: It is an addiction to alcohol and/or drugs. It is also the compulsive behavior that results from this addiction.
  - This addiction makes it hard for a person to function well with other people.
  - It makes it hard for a person to function well in the work that they do.
  - It will also cause person's body and mind to become quite ill if the alcohol and/or drugs are taken away.
- The Health Benefit Plan will provide coverage for the care and treatment of Alcohol Or Drug Abuse And Dependency based on the services provided and reported by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.
- A Referral from the Member's Primary Care Physician is not required to obtain Inpatient or Outpatient Alcohol Or Drug Abuse And Dependency treatment.
- To Access Treatment for Alcohol Or Drug Abuse And Dependency:
  - Contact the Member's Primary Care Physician; or
  - Call the behavioral health management company at the phone number shown on the Member's ID Card.

- <u>Inpatient Treatment</u>
  - Covered Services include:
    - The diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency, including Detoxification;
    - At a Participating Facility Provider that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

  Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling, during an Inpatient Alcohol Or Drug Abuse And Dependency treatment admission in an Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

  Covered Services include:
    - Lodging and dietary services;

- Diagnostic services, including psychiatric, psychological and medical laboratory tests;
- Services provided by a staff Physician, a Psychologist, a registered or Licensed Practical Nurse, and/or a certified addictions counselor;
- Rehabilitation therapy and counseling;
- Family counseling and intervention; and
- Prescription Drugs, medicines, supplies and use of equipment provided by the Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

- Outpatient Treatment
  - Covered Services include:
    - The diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency, including Detoxification;
    - At a Participating Facility Provider that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

  Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling, during an Inpatient Alcohol Or Drug Abuse And Dependency treatment admission in an Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

  Covered Services include:
    - Diagnostic services, including psychiatric, psychological and medical laboratory tests;
    - Services provided by the Behavioral Health/Alcohol And Drug Abuse Or Dependency Provider on staff;
    - Rehabilitation therapy and counseling;
    - Family counseling and intervention; and
    - Medication management and use of equipment and supplies provided by the Alcohol And Drug Abuse Or Dependency or a Residential Treatment Facility that is a Behavioral Health/ Alcohol And Drug Abuse Or Dependency Provider.

OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, Services for Outpatient Care are Covered Services when:
- Deemed Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preapproved by the Health Benefit Plan.

If the Member receives services that result from a Referral to a Non-Participating Provider, the following will apply:
- They will be covered, when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Health Benefit Plan.
- The Referral will be valid for 90 days from the date it was issued. This is the case, so long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider, contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Health

Benefit Plan about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:
- This will require yet another electronic referral from the Member's Primary Care Physician.

Self Referrals are excluded, except for Emergency Services or if covered by a Rider. The only time the Member can refer their self is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

Ambulance Services

The Health Benefit Plan will provide coverage for Emergency ambulance services. However, these services need to be:
- Medically Necessary as determined by the Health Benefit Plan; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when all the following applies;
  - The vehicle is licensed as an ambulance, where required by applicable law;
  - The ambulance transport is appropriate for the Member's clinical condition;
  - The use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would endanger the Member's medical condition; and,
  - The ambulance transport satisfies the destination and other requirements as stated under Regarding Emergency Ambulance transport or Regarding Non-Emergency Ambulance transports provisions below.

Benefits are payable for air or sea ambulance transportation only if the Member's condition, and the distance to the nearest facility able to treat the Member's condition, justify the use of an alternative to land transport.

- Regarding Emergency Ambulance transport: The ambulance must be transporting the Member:
  - From the Member's home, or the scene of an accident or Medical Emergency;
  - To the nearest Hospital, or other Emergency Care Facility, that can provide the Medically Necessary Covered Services for the Member's condition.
- Regarding Non-Emergency Ambulance transport: All non-emergency ambulance transports must be Preapproved by the Health Benefit Plan to determine Medical Necessity which includes specific origin and destination requirements specified in the Health Benefit Plan's policies.
  - Non-emergency air or ground transport may be covered to return the Member to a Participating Facility Provider within the Member's Service Area for required continuing care (when a Covered Service), when such care immediately follows an Inpatient emergency admission and the Member is not able to return to the Service Area by any other means. This type of transportation is provided when the Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport that cannot be safely provided by land ambulance. Transportation back to the Service Area will not be covered for family members or companions.
- Non-emergency ambulance transports are not provided for the convenience of the Member, the family, or the Provider treating the Member.

Dental (Pediatric)

The Health Benefit Plan will provide coverage for Dental (Pediatric) benefits described in this provision for Members under 19 years of age.

- The following are shown on the ***Schedule of Covered Services***, if applicable:
  - Benefits
  - Copayments
  - Deductibles
  - Deductibles
  - Lifetime Maximums
  - Out-of-Pocket Maximums
  - Waiting Periods

- Services shown on the **Schedule of Covered Services** as covered are subject to:
  - Frequency; or
  - Age limitations that are detailed on the schedule, as well as the Exclusions provision listed in the **Exclusions – What is Not Covered** section.

    Only:
    - Services;
    - Supplies; and
    - Procedures: Listed on the ***Schedule of Covered Services*** are Covered Services.

    For items not listed (not covered):
  - The Member is responsible for the full fee charged by the Dentist.

No benefits will be paid for services, supplies or procedures detailed in the ***Exclusions – What is Not Covered*** section.

It is important to remember the following about the Member's Dental (Pediatric) benefits:

- Member Cost Share
  - Not all dental procedures are covered.
  - If the procedure is not listed on ***Schedule of Covered Services***, it is not covered.
  - The Member will be responsible to pay the their Dentist the full charge for the uncovered service.
- Regarding Copayments:
  - Certain procedures listed on the ***Schedule of Covered Services*** require the Member to pay a Copayment. Copayments are listed in the right-hand column on the Schedule.
  - The Member is responsible to pay the Copayments at the time of service unless they have made other arrangements with the Primary Dental Office or Specialty Care Dentist.
  - Copayments are the same whether the service is provided by the Member's Primary Dentist or by a Specialty Care Dentist through referral.
  - Services listed on the ***Schedule of Covered Services*** with a “0" in the right-hand column require no Copayment from the Member.

  Services listed on the ***Schedule of Covered Services*** are also subject to Exclusions and Limitations.

  Be sure to review:
  - The ***Schedule of Covered Services***; and
  - The list of Exclusions listed in the ***Exclusions – What is Not Covered*** section.

Services not listed on the following are not covered and are the Member's responsibility:

- ***Schedule of Covered Services***;
- Exclusions; or
- Those beyond stated Limitations.

- Other Charges for Alternative Treatment
  - All diagnosis and treatment planning is provided by the Member's Primary Dental Office. Frequently, several alternate methods exist to treat a dental condition.
    For example:
    - A tooth can be restored with a crown or a filling; and
    - Missing teeth can be replaced either with a fixed bridge or a partial denture.
  - The Health Benefit Plan will make payment based upon the allowance for the less expensive procedure;
    - Provided that the less expensive procedure meets accepted standards of dental treatment.
  - The Health Benefit Plan decision does not commit the Member to the less expensive procedure.
    However:
  - If the Member and the Dentist choose the more expensive procedure:
    - The Member is responsible for the additional charges beyond those paid or allowed by the Health Benefit Plan.

  Occasionally, the Member and the Member's Primary Dental Office may consider alternative treatment plans that are not Covered Services.

  In those instances: The Member is responsible for the additional cost for the alternative treatment.
  The cost of the alternative treatment will be calculated:
  - On the difference between the provider's usual fee for the alternative treatment; and
  - The usual fee for the Covered Service plus the Copayment of the Covered Service.

- **Payment of Benefits**
  The Health Benefit Plan will pay covered benefits:
  - Directly to the Member's assigned Primary Dental Office; or
  - The Specialty Care Dentist.

  Payment is based on allowances contracted with In-Network Dentists.

  All contracts between the Health Benefit Plan and the In-Network Dentists state: That under no circumstances will the Member be liable to any Dentist for any sum owed by the Health Benefit Plan to the Dentist.

  In any instance where the Health Benefit Plan fails or refuses to pay the Dentist: Such dispute is solely between the Dentist and the Health Benefit Plan.

  Other than Copayments, the Member is not liable for any monies the Health Benefit Plan fails or refuses to pay.

- **How To Access Dental Care**
  - Choice of Provider at Enrollment
    - The Member must select a Primary Dental Office.
    - Each Member may select a different Primary Dental Office.
    - The Primary Dental Offices will be notified of the Member's selection or assignment.

  To find a Primary Dental Office, call Customer Service at the telephone number shown on the ID card.
  - Once enrolled:
    - The Member will receive an ID Card; or
    - Other notification;
  - Indicating:
    - The Member's contract ID number; and
    - Plan number.
  - Present:
    - The Member ID card to the Member's dental office; or
    - Give the office the Member's ID number and Plan number.

  If the Member's Dentist has questions about their eligibility or benefits, instruct the office to call the Health Benefit Plan.

- **Changing Primary Dental Offices**

  The Member may request to change Primary Dental Offices at any time.
  - Simply call Customer Service at the telephone number shown on the ID Card. The Member will be informed of:
    - The effective date of their transfer; and
    - The newly selected office will also be notified.
  - The Member must request the transfer prior to seeking services from the new Primary Dental Office.
  - Any dental procedures in progress must be completed before the transfer.
  - If the Member is enrolled in a Primary Dental Office that stops participating in the Program, the Health Benefit Plan will notify the Member and assist the Member with selecting another Primary Dental Office.

- **Coordination of Care and Referrals**

  The Primary Dental Office assigned to the Member must provide or coordinate all Covered Services.

  When specialty care such as:
  - Surgical treatment of the gums; or
  - A root canal is needed;
    - The Primary Dentist may perform the procedure; or
    - Give the Member a written referral to a Specialty Care Dentist.

  With the exception of:
  - Dental Emergencies; or
  - If a Primary Dentist or Specialty Care Dentist is not available in the Member's area:
    - All benefits must be provided by an In-Network Dentist.

  When specialty care such as surgical treatment of the gums or a root canal is needed, the Primary Dentist may perform the procedure or refer the Member to a specialist.

- All referrals must be made to a participating Specialty Care Dentist.
- The Member's Primary Dentist will give them a written referral to take to the Specialty Care Dentist.
- The Specialty Care Dentist will perform the treatment and submit a claim and the referral to the Health Benefit Plan for processing.
  - The claim will be denied if the written referral is not submitted.
  - Referral is limited to endodontic, orthodontic, periodontic, oral surgery, and pedodontic Specialty Care Dentists.

Should the Member have any questions concerning their coverage, eligibility or a specific claim, contact the Health Benefit Plan's Customer Service at the telephone number shown on the ID Card.

- Orthodontic Coverage

With regard to Orthodontic coverage, "Medically Necessary" or "Medical Necessity" shall mean:

Health care services that a Physician or Dentist:

- Exercising prudent clinical judgment;
- Would provide to a patient for the purpose of;
  - Evaluating;
  - Diagnosing; or
  - Treating an illness, injury, disease; or
  - Its symptoms; and

  That are:
    - In accordance with the generally accepted standards of medical/dental practice;
    - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
    - Not primarily for the convenience of the patient or Physician/Dentist, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

As used the first bullet above, "generally accepted standards of medical/dental practice" means:

- Standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- Recognized Medical/Dental and Specialty Society recommendations;
- The views of Physicians/Dentists practicing in the relevant clinical area; and
- Any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

- Regarding coverage of Medically Necessary Orthodontics: Orthodontic treatment must be Medically Necessary and be the only method capable of:
  - Preventing irreversible damage to the Member's teeth or their supporting structures and,
  - Restoring the Member's oral structure to health and function.
- Members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services.

- All Medically Necessary orthodontic services require prior approval and a written plan of care.

Diabetic Education Program

When prescribed by a Participating Professional Provider legally authorized to prescribe such items under law, the Health Benefit Plan will provide coverage for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of:

- Insulin-dependent diabetes;
- Insulin-using diabetes;
- Gestational diabetes; and
- Noninsulin-using diabetes.

A Referral from the Member's Primary Care Physician is not required to obtain services for the Diabetic Education Program benefits.

When Physician certification must occur: The attending Physician must certify that a Member requires diabetic education on an Outpatient basis, under the following circumstances:

- Upon the initial diagnosis of diabetes;
- Upon a significant change in the Member's symptoms or condition; or
- Upon the introduction of new medication or a therapeutic process in the treatment or management of the Member's symptoms or condition.

Requirements that must be met: Outpatient diabetic education services will be covered when they meet specific requirements.

- These requirements are based on the certification programs for Outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.
- Specific requirements: Outpatient diabetic education services and education program must:
  - Be provided by a Participating Provider
  - Be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Health Benefit Plan.

Covered Services include Outpatient sessions that include, but may not be limited to, the following information:

- Initial assessment of the Member's needs;
- Family involvement and/or social support;
- Psychological adjustment for the Member;
- General facts/overview on diabetes;
- Nutrition including its impact on blood glucose levels;
- Exercise and activity;
- Medications;
- Monitoring and use of the monitoring results;
- Prevention and treatment of complications for chronic diabetes, (That is, foot, skin and eye care);
- Use of community resources; and
- Pregnancy and gestational diabetes, if applicable.

Diabetic Equipment and Supplies

- Coverage and costs: The Health Benefit Plan will provide coverage for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. This is subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits

- When equipment and supplies can be purchased at a pharmacy: This Program provides benefits for Prescription Drugs:
  - Certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, if available.
  - This will be subject to the cost-sharing arrangements, applicable to the prescription drug coverage.
- When equipment is not available at a pharmacy:
  - The diabetic equipment will be provided under the Durable Medical Equipment benefit;
  - This will be subject to the cost-sharing arrangements applicable to Durable Medical Equipment.
- Covered Diabetic Equipment:
  - Blood glucose monitors;
  - Insulin pumps;
  - Insulin infusion devices; and
  - Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

Covered Diabetic Supplies:

- Blood testing strips;
- Visual reading and urine test strips;
- Insulin and insulin analogs;
- Injection aids;
- Insulin syringes;
- Lancets and lancet devices;
- Monitor supplies;
- Pharmacological agents for controlling blood sugar levels; and
- Glucagon emergency kits.

Diagnostic Services

The Health Benefit Plan will provide coverage for the following Diagnostic Services, when ordered by a Participating Professional Provider; and billed by a Referred Specialist and/or a Participating Facility Provider:

- Routine Diagnostic Services, including:
  - Routine radiology: Consisting of x-rays, ultrasound, and nuclear medicine;
  - Routine medical procedures: Consisting of ECG, EEG, Nuclear Cardiology Imaging and other diagnostic medical procedures approved by the Health Benefit Plan; and
  - Allergy testing: Consisting of percutaneous, intracutaneous and patch tests.
- Non-Routine Diagnostic Services, including:
  - Operative and diagnostic endoscopies;
  - MRI/MRA;
  - CT Scans,
  - PET Scans; and
  - Sleep Studies.
- Diagnostic laboratory and pathology tests.
- Genetic testing and counseling.
  This includes services provided to a Member at risk for a specific disease that is a result of:
  - Family history; or
  - Exposure to environmental factors that are known to cause physical or mental disorders.

  When clinical usefulness of specific genetic tests has been established by the Health Benefit Plan, these services are covered for the purpose of:
  - Diagnosis;
  - Screening;
  - Predicting the course of a disease;
  - Judging the response to a therapy;
  - Examining risk for a disease; or
  - Reproductive decision-making.

Durable Medical Equipment

The Health Benefit Plan will provide coverage for the rental (but not to exceed the total allowance) or, at the option of the Health Benefit Plan, the purchase of Durable Medical Equipment when:

- It is used in the Member 's home; and
- It is obtained through a Participating Durable Medical Equipment Provider.

Replacement and Repair

The Health Benefit Plan will provide coverage for the repair or replacement of Durable Medical Equipment when the equipment:

- Does not function properly; and
- Is no longer useful for its intended purpose, in the following limited situations:
  - Due to a change in a Member's condition: When a change in the Member's condition requires a change in the Durable Medical Equipment the Health Benefit Plan will provide repair or replacement of the Equipment;
  - Due to breakage: When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Health Benefit Plan will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Health Benefit Plan.

Breakage under warranty: If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of:

- The Health Benefit Plan in the case of rented equipment; and
- The Member, in the case of purchased equipment.

Breakage during reasonable useful lifetime: The Health Benefit Plan will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty. For example, the Health Benefit Plan will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

Cost to repair vs. cost to replace: The Health Benefit Plan will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment:

- Replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning.
- A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage or defect.

Home Health Care

- Covered Services: The Health Benefit Plan will provide coverage for the following services when performed by a licensed Home Health Care Provider:
  - Professional services of appropriately licensed and certified individuals;
  - Intermittent Skilled Nursing Care;
  - Physical Therapy;
  - Speech Therapy;
  - Well mother/well baby care following release from an Inpatient maternity stay; and

  - Care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy.
- Regarding well mother/well baby care: With respect to well mother/well baby care following early release from an Inpatient maternity stay, Home Health Care services must be provided within 48 hours if:
  - Discharge occurs earlier than 48 hours of a vaginal delivery; or
  - Discharge occurs earlier than 96 hours of a cesarean delivery.

  No cost sharing shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.
- Regarding other medical services and supplies: Benefits are also provided for certain other medical services and supplies, when provided along with a primary service. Such other services and supplies include:
  - Occupational Therapy;
  - Medical social services; and
  - Home health aides in conjunction with skilled services and other services which may be approved by the Health Benefit Plan.
- Regarding Medical Necessity: Home Health Care benefits will be provided only when prescribed by the Member's attending Physician, in a written Plan Of Treatment and approved by the Health Benefit Plan as Medically Necessary.
- Regarding the issue of being confined: There is no requirement that the Member be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.
- Regarding being Homebound: With the exception of Home Health Care provided to a Member, immediately following an Inpatient release for maternity care, the Member must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

Limitations: This benefit is subject to the limits shown in the ***Schedule of Covered Services***.

Injectable Medications

The Health Benefit Plan will provide coverage for injectable medications required in the treatment of an injury or illness when administered by a Participating Professional Provider.

- Specialty Drugs
  - Refers to a medication that meets certain criteria including, but not limited to:
    - The drug is used in the treatment of a rare, complex, or chronic disease;
    - A high level of involvement is required by a healthcare Provider to administer the drug;
    - Complex storage and/or shipping requirements are necessary to maintain the drug's stability;
    - The drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance; and
    - Access to the drug may be limited.

  Preapproval is required for those Specialty Drugs noted in the Preapproval list which is available on-line or by calling Customer Service at the phone number shown on the Member's ID card. The purchase of any Specialty Drug is subject to the cost sharing as shown on the ***Schedule of Covered Services***.

- Standard Injectable Drugs
  - Standard Injectable Drugs refer to a medication that is either injectable or infusible, but is not defined by the Health Benefit Plan to be a Self-Administered Prescription Drug or a Specialty Drug.
  - These include, but are not limited to:
    - Allergy injections and extractions; and
    - Injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.
  - Self-Administered Prescription Drugs generally are not covered.
  - For more information on Self-Administered Prescription Drugs:
    - Please refer to the ***Exclusions - What Is Not Covered.***

Medical Foods and Nutritional Formulas

- The Health Benefit Plan will provide coverage for Medical Foods when provided for the therapeutic treatment of inherited errors of metabolism (IEMs) such as:
  - Phenylketonuria;
  - Branched-chain ketonuria;
  - Galactosemia; and
  - Homocystinuria.
  - Coverage is provided when administered on an Outpatient basis, either orally or through a tube.

- The Health Benefit Plan will provide coverage for Nutritional Formulas when the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, that does not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.
-

The Health Benefit Plan will provide coverage for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment supplier or in connection with Infusion Therapy as provided for in this Program.

An estimated basal caloric requirement for medical foods and Nutritional Formula is not required for IEMs.

Non-Surgical Dental Services

The Health Benefit Plan will provide coverage only for:

- The initial treatment of Accidental Injury/trauma, (That is, fractured facial bones and fractured jaws), in order to restore proper function.

  Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, required for the initial treatment for the Accidental Injury/trauma. This includes:
  - The first caps;
  - Crowns;
  - Bridges; and
  - Dentures (but not dental implants).
- The preparation of the jaws and gums required for initial replacement of Sound Natural Teeth.

Orthotics (Devices Used for Support of Bones and Joints)

The Health Benefit Plan will provide coverage for:

- The first purchase and fitting: This is the initial purchase and fitting (per medical episode) of orthotic devices which are Medically Necessary as determined by the Health Benefit Plan. This does not include foot orthotics, unless the Member requires foot orthotics as a result of diabetes.
- Replacements due to growth: The replacement of covered orthotics for Dependent children when required due to natural growth.

Note: Foot orthotics, ordered and covered as a result of diabetes, must be purchased through a Participating Durable Medical Equipment Provider.

Prescription Drugs

The Health Benefit Plan will provide benefits for Prescription Drugs for Covered Drugs Or Supplies dispensed by a Prescription Order Or Refill for use when a Member is not an inpatient. Benefits for Covered Drugs Or Supplies are subject to cost sharing as shown on the ***Schedule of Covered Services*** under Prescription Drug and included in the Prescription Drug Limitations.

In certain cases, the Health Benefit Plan may determine that the use of certain Covered Drugs Or Supplies for a Member's medical condition requires Preapproval for Medical Necessity.

In certain cases where the Health Benefit Plan determines there may be Prescription Drug usage by a Member that exceeds what is generally considered appropriate under the circumstances, the Health Benefit Plan has the right to direct that Member to one Pharmacy for all future Covered Drugs Or Supplies.

The Health Benefit Plan provides benefits for the Member's Covered Drugs Or Supplies as described below:

- Contraceptives Drugs and Devices– Coverage includes benefits for Contraceptive Drugs and Devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordability.
- Dermatological Drugs - Compounded dermatological preparations containing at least one Federal Legend or State Restricted Drug.
- Drugs From a Non-Participating Pharmacy - Covered Drugs Or Supplies furnished by a Non-Participating Pharmacy when the Member submits acceptable proof of payment with a direct reimbursement form. Reimbursement for Covered Drugs or Supplies will not exceed 30% of the usual and customary charge. The Member will be entitled to reimbursement only if their purchase is related to Covered Services for Emergency Care or Urgent Care out of the Service Area. The Member must submit acceptable proof of payment with a direct reimbursement form. All claims for payment must be received within 90 days of the date of proof of purchase. Direct reimbursement forms may be obtained by contacting the Customer Service Department.
- Drugs From a Participating Pharmacy - Covered Drugs Or Supplies furnished by a Participating Pharmacy without charge except for the Prescription Drug cost sharing for each Prescription Order Or Refill. Cost sharing, Limitations, or maximums are listed on the ***Schedule of Covered Services.***
- Drugs From a Participating Mail Service Pharmacy – Covered Drugs or Supplies furnished by a Participating Mail Service Pharmacy subject to the Prescription Drug cost sharing for each Prescription Order or Refill.

- Insulin - only by Prescription Order Or Refill. Coverage includes, insulin, disposable insulin needles and syringes, diabetic blood testing strips, lancets and glucometers. There is no Prescription Drug cost sharing requirement for lancets and glucometers obtained through a Participating Pharmacy or a Participating Mail Service Pharmacy.
- Over-the-Counter Drugs - Prescription Drug Benefits cover insulin and certain over-the-counter drugs that are prescribed by a physician in accordance with applicable law.
- Prescribing Physician - Covered Drugs Or Supplies, and covered Maintenance Prescription Drugs Prescribed by the Member's Primary Care Physician or Referred Specialist and furnished by a Participating Pharmacy. Generically equivalent pharmaceuticals will be dispensed whenever applicable. Prescription Drugs contained in the Drug Formulary will be Prescribed and dispensed whenever appropriate, pursuant to the professional judgment of the Primary Care Physician, Referred Specialist and/or the Pharmacist. Covered Drugs not listed in the Drug Formulary shall be subject to the Non-Formulary Drug Copay. To obtain a copy of the Formulary, the Member should call Customer Service at the phone number shown on the ID Card.
- Self-Injectable Medications – Benefits are provided for Self-Injectable Covered Drugs Or Supplies.
- Specialty Drugs - The Health Benefit Plan will only provide benefits for covered Specialty Drugs, except Insulin, through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program for the appropriate cost sharing indicated in the Schedule of Benefits for a Participating Pharmacy. Benefits are available for up to a 30 day supply. If the Member's doctor wants the Member to start the drug immediately, an initial supply may be obtained at a retail Pharmacy. However, all subsequent fills must be purchased through the PBM's Specialty Pharmacy Program. No benefits shall be provided for Prescription Drugs obtained from a Specialty Pharmacy Program other than the PBM's Specialty Pharmacy Program. It is the Member's responsibility to initiate the Specialty Pharmacy process.

  Select specialty drugs will be subject to 'split fill' whereby the initial prescription will be dispensed in two separate amounts. The first amount is dispensed without delay. The second amount may be dispensed subsequently, allowing time for any necessary clinical intervention due to medication side effects that may require dose modification or therapy discontinuation. The Member's cost share is prorated for each amount of the split fill.

- Vitamins that require a Prescription Order or Refill.

The Health Benefit Plan requires Preapproval (by the Member's Physician) for certain drugs to ensure that the prescribed drug is medically appropriate. Where Preapproval or quantity level limits are imposed, the Member's Physician may request an exception for coverage by providing documentation of Medical Necessity. The Member may obtain information about how to request an exception by calling Customer Service at the phone number on the Member's ID Card.

The Member, or their Physician acting on the Member's behalf, may appeal any denial of benefits through the Complaint Appeal and Grievance Appeal Process described in the Benefit Booklet.

Prosthetic Devices

The Health Benefit Plan will provide coverage for Prosthetic Devices required as a result of illness or injury. Benefits include but are not limited to:

- The purchase and fitting, and the necessary adjustments and repairs, of Prosthetic Devices and supplies (except dental prostheses);

- Supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
- Visual Prosthetics when Medically Necessary and Prescribed for one of the following conditions:
  - Initial contact lenses Prescribed for the treatment of infantile glaucoma;
  - Initial pinhole glasses Prescribed for use after Surgery for detached retina;
  - Initial corneal or scleral lenses Prescribed in connection with the treatment of keratoconus or to reduce a corneal irregularity (other than astigmatism);
  - Initial scleral lenses Prescribed to retain moisture in cases where normal tearing is not present or adequate; and
  - An initial pair of basic eyeglasses when Prescribed to perform the function of a human lens lost (aphakia) as a result of Accidental Injury, Trauma, or Ocular Surgery.

The “Repair and Replacement” paragraphs set forth below do not apply to this item.

The Health Benefit Plan will provide coverage for the replacement of a previously approved Prosthetic Device with an equivalent Prosthetic Device when:
- There is a significant change in the Member's condition that requires a replacement;
- The Prosthetic Device breaks because it is defective;
- The Prosthetic Device breaks because it has exceeded its life duration as determined by the manufacturer; or
- The Prosthetic Device needs to be replaced for a Dependent child due to the normal growth process when Medically Necessary.

The Health Benefit Plan will provide coverage for the repair of a Prosthetic Device when the cost to repair is less than the cost to replace it. Repair means the restoration of the Prosthetic Device or one of its components to correct problems due to wear or damage. Replacement means the removal and substitution of the Prosthetic Device or one of its components necessary for proper functioning.

If an item breaks and is under warranty, it is the Member’s responsibility to work with the manufacturer to replace or repair it.

The Health Benefit Plan will neither replace nor repair the Prosthetic Device due to abuse or loss of the item.

Specialist Office Visit

The Health Benefit Plan will provide coverage for Specialist Services Medical Care provided in the office by a Referred Specialist other than a Primary Care Provider

For the purpose of this benefit “in the office” includes:
- Medical Care visits to a Provider’s office;
- Medical Care visits by a Provider to the Member’s residence; or
- Medical Care consultations by a Provider on an Outpatient basis.

Spinal Manipulation Services

- The Health Benefit Plan will provide coverage for the detection and correction of structural imbalance or dislocation (subluxation) of the Member’s spine resulting from, or related to any of the following:
- Distortion of, or in, the vertebral column;

- Misalignment of, or in, the vertebral column; or
- Dislocation (Subluxation) of, or in, the vertebral column.

The detection and correction can be done by manual or mechanical means (by hand or machine).
This service will be provided, up to the limits specified in the ***Schedule of Covered Services*** for spinal manipulations.

Therapy Services (Rehabilitative and Habilitative Services)

The Health Benefit Plan will provide coverage for the following forms of therapy:

- Cardiac Rehabilitation Therapy
  Refers to a medically supervised rehabilitation program designed to improve a Member's tolerance for physical activity or exercise.

- Chemotherapy
  Chemotherapeutic agents, if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes) will be covered. The cost of Prescription Drugs, approved by the Federal Food and Drug Administration (FDA) and only for those uses for which such drugs have been specifically approved by the FDA as antineoplastic agents is covered, provided they are administered as described in this paragraph.

- Dialysis
  Dialysis treatment when provided in the Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in the home. In the case of home Dialysis, Covered Services will include equipment, training, and medical supplies. Private Duty Nursing is not covered as a portion of Dialysis. The decision to provide Covered Services for the purchase or rental of necessary equipment for home Dialysis will be made by the Health Benefit Plan. The Covered Services performed in a Participating Facility Provider or by a Participating Professional Provider for Dialysis are available without a Referral.

- Infusion Therapy
  - The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a healthcare Provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (For example, home, office, Outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Health Benefit Plan.

- Occupational Therapy
  Coverage will also include services rendered by a registered, licensed occupational therapist. The Member is required to have these services performed by the Member's Primary Care Physician's Designated Provider.

- Physical Therapy
  Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio- mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body

part. The Member is required to have these services performed by the Member's Primary Care Physician's Designated Provider.

- Pulmonary Rehabilitation Therapy
  Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

- Radiation Therapy

The treatment of disease by x-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

- Respiratory Therapy
  Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

- Speech Therapy
  Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

Urgent Care Centers

The Health Benefit Plan will provide coverage for Urgent Care Centers, when Medically Necessary as determined by the Health Benefit Plan.

- Urgent Care Centers are designed to offer immediate evaluation and treatment for health conditions that require medical attention:
  - In a non-Emergency situation;
  - That cannot wait to be addressed by the Member's Participating Professional Provider or Retail Clinic.

Cost-sharing requirements are specified in the ***Schedule of Covered Services***.

Vision Care

Vision screening to determine the need for refraction when performed by the Member's Primary Care Physician.

Vision (Adult)

- Vision Examination
  Each Member may have one routine eye exam and refraction every *one calendar year*. These services must be provided by a Participating Provider. A list of Participating Providers is available through Customer Service.

- Prescription Lenses And Frames From A Participating Provider
  Each Member over the age of 19 is entitled to the following benefits for vision frames and prescription lenses once every one calendar year when provided by a Participating Provider. A list of Participating Providers is available through Customer Service.

  - One pair of frames from a select group of frames; and

- One set of eyeglass lenses that may be plastic or glass lenses, single, bifocal, or trifocal lenses, lenticular lenses, polycarbonate lenses and monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters and/or oversized lenses.

Vision (Pediatric)

- Vision Examination
  Each Member may have one routine eye exam and refraction every *one calendar year*. These services must be provided by a Participating Provider. A list of Participating Providers is available through Customer Service.

- Prescription Lenses And Frames From A Participating Provider
  Each Member under the age of 19 is entitled to the following benefits for vision frames and prescription lenses once every one calendar year when provided by a Participating Provider. A list of Participating Providers is available through Customer Service.

  - One pair of frames from a select group of frames; and
  - One set of eyeglass lenses that may be:
    - Plastic or glass lenses;
    - Single;
    - Bifocal or trifocal lenses;
    - Lenticular lenses; or
    - Polycarbonate lenses;
    - For Dependent children and monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters and/or oversized lenses.

  - Frames and prescription lenses covered by this Program and described in this Benefit Booklet are limited to the Pediatric Frame Selection of covered frames and prescription lenses.
  - The Participating Provider will show the Member the selection of frames and prescription lenses covered by this Program.
  - If the Member selects a frame or prescription lenses that are not included in the Pediatric Frame Selection covered under this Program, the Member is responsible for:
  - The difference in cost between the Participating Provider reimbursement amount for covered frames and prescription lenses from the Pediatric Frame Selection; and
  - The retail price of the frame and prescription lenses selected.
  - Any amount paid to the Participating Provider for the difference in cost of a non-Pediatric Frame Selection frame or prescription lenses will not apply to any applicable Deductible or out-of-pocket maximum.

EMERGENCY AND URGENT CARE

WHAT ARE EMERGENCY SERVICES?

"Emergency Services" are any health care services provided to a Member after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member or with respect to a pregnant Member, the health of the Member or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency transportation and related Emergency Service provided by a licensed ambulance service shall constitute an Emergency Service.

Emergency Services Inside and Outside the Service Area.

Emergency Services are covered whether they are provided inside or outside Keystone's Service Area. Emergency Services do not require a Referral for treatment from the Member's Primary Care Physician. The Member must notify their Primary Care Physician to coordinate all continuing care. Medically Necessary Care by any Provider other than the Member's Primary Care Physician will be covered until the Member can, without medically harmful consequences, be transferred to the care of the Member's Primary Care Physician or Referred Specialist.

Note: It is the Member's responsibility to contact the Health Benefit Plan for any bill the Member receives for Emergency Services or out-of- area Urgent Care provided by a Non-Participating Provider. If the Member receives any bills from the Provider, the Member needs to contact Customer Service at the telephone number on the Member's ID card. When the Member notifies the Health Benefit Plan about these bills, the Health Benefit Plan will resolve the balance billing.

Examples of conditions requiring Emergency Services are: excessive bleeding; broken bones; serious burns; sudden onset of severe chest pain; sudden onset of acute abdominal pains; poisoning; unconsciousness; convulsions; and choking.

MEDICAL SCREENING EVALUATION

Medical Screening Evaluation services will be Covered Services when performed in a Hospital emergency department for the purposes of determining whether or not an Emergency exists.

NOTE: If the Member believes they need Emergency Services, the Member should call 911 or go immediately to the emergency department of the closest Hospital. Coverage of reasonably necessary costs associated with Emergency Services provided during the period of the Emergency are covered by this Program.

WHAT IS URGENT CARE?

"Urgent Care" needs are for sudden illness or Accidental Injury that requires prompt medical attention, but are not life threatening and are not Emergency medical conditions, when the Member's Primary Care Physician is unavailable. Examples of Urgent Care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not Preventive Care or Follow-up Care.

Urgent Care Inside Keystone's Service Area
If the Member is within the Service Area and they need Urgent Care, they call their Primary Care Physician first. The Member's Primary Care Physician provides coverage 24 hours a day, seven days a week for Urgent Care. The Member's Primary Care Physician, or the Physician covering for their Primary Care Physician, will arrange for appropriate treatment. Urgent Care services may also be accessed directly at an Urgent Care Center or Retail Clinic.
Urgent Care provided within the Service Area will be covered only when provided or Referred by the Member's Primary Care Physician, or when provided at an Urgent Care Center or Retail Clinic without a Referral.

WHAT IS FOLLOW-UP CARE?
"Follow-Up Care" is Medically Necessary follow-up visits that occur while the Member is outside Keystone's Service Area. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is in the Health Benefit Plan's Service Area. An example is Dialysis. Follow-Up Care must be Preapproved by the Member's Primary Care Physician prior to traveling. This service is available for temporary absences (less than 90 consecutive days) from the Health Benefit Plan's Service Area.

ACCESS TO COVERED SERVICES OUTSIDE KEYSTONE'S SERVICE AREA
Members have access to health care services when traveling outside of Keystone's service area. The length of time that the Member will be outside the Service Area will determine whether benefits will be available through the BlueCard Program or the Away From Home Care Guest Membership Program.

Out of pocket costs for Covered Services are limited to applicable Copayments. A claim form is not required to be submitted in order for a Member to receive benefits for Covered Services, provided the Member meets the requirements identified below.

THE BLUECARD®PROGRAM
Through the BlueCard Program, Urgent Care Benefits cover Medically Necessary treatment for any unforeseen illness or injury that requires treatment prior to when the Member returns to Keystone's Service Area. Covered Services for Urgent Care are provided by a contracting Blue Cross and Blue Shield Association traditional participating Provider ("BlueCard Provider"). Coverage is for Medically Necessary services required to prevent serious deterioration of the Member's health while traveling outside Keystone's Service Area during a temporary absence (less than 90 consecutive days). After that time, the Member must return to Keystone's Service Area or be disenrolled automatically from the Group's plan, unless the Member is enrolled as a Guest Member under the Away From Home Care Guest Membership Program (see below).

Emergency Care Services: If the Member experiences a Medical Emergency while traveling outside Keystone's Service Area, go to the nearest Emergency or Urgent Care facility.

Urgent Care required during a temporary absence will be covered when:
- The Member calls 1-800-810-BLUE. This number is available 24 hours a day, seven days a week.
- The Member will be given the names, addresses and phone numbers of three BlueCard Providers. The BlueCard Program has some international locations. When the Member calls, the Member will be asked whether the Member is inside or outside of the United States.
- The Member decides which Provider the Member will visit.

- The Member calls 1-800-ASK-BLUE to get prior authorization for the service from Keystone.
- With Keystone's approval, the Member calls the Provider to schedule an appointment. The BlueCard Provider confirms Member eligibility.
- The Member shows their ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of the Member's visit.

Follow-Up Care Benefits under the BlueCard Program
Follow-Up Care Benefits under the BlueCard Program cover Medically Necessary Follow-Up Care required while the Member is traveling outside of Keystone's Service Area. The care must be needed for urgent ongoing treatment of an injury, illness, or condition that occurred while the Member was in Keystone's Service Area. Follow- Up Care must be pre-arranged and Preapproved by the Member's Primary Care Physician and the health plan in Keystone's Service Area prior to leaving the Service Area. Under the BlueCard Program, coverage is provided only for the specified, Preapproved service(s) authorized by the Member's Primary Care Physician in Keystone's Service Area and Keystone's Care Management and Coordination Department. Follow-Up Care Benefits under the BlueCard Program are available during the Member's temporary absence (less than 90 consecutive days) from Keystone's Service Area.

Follow-Up Care required during a temporary absence (less than 90 consecutive days) from Keystone's Service Area will be covered when these steps are followed:
- The Member is currently receiving urgent ongoing treatment for a condition.
- The Member plans to go out of Keystone's Service Area temporarily, and the Member's Primary Care Physician recommends that the Member continues treatment.
- The Member's Primary Care Physician must call 1-800-ASK-BLUE to get prior authorization for the service from Keystone. If a BlueCard Provider has not been pre-selected for the Follow-Up Care, the Member's Primary Care Physician or the Member will be told to call 1-800-810-BLUE.
- The Member or the Member's Primary Care Physician will be given the names, addresses and phone numbers of three BlueCard Providers.
- Upon deciding which BlueCard Provider will be visited, the Member or the Member's Primary Care Physician must inform Keystone by calling the number on the ID Card.
- The Member should call the BlueCard Provider to schedule an appointment.
- The BlueCard Provider confirms the Member's eligibility.
- The Member shows the Member's ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of the Member's visit.

Additional Information about the BlueCard Program
Whenever the Member accesses covered healthcare services outside Keystone's Service Area and the claim is processed through the BlueCard Program, the amount the Member pays for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:
- The billed covered charges for the Member's Covered Services; or
- The negotiated price that the Host Blue makes available to Keystone.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue provides coverage for the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over-or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Keystone uses for the Member's claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the Member's calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate the Member's liability for any covered healthcare services according to applicable law.

THE AWAY FROM HOME CARE®PROGRAM

If the Member plans to travel outside Keystone's Service Area for at least 90 consecutive days, and the Member is traveling to an area where a Host HMO is located, the Member may be eligible to register as a Guest Member under the Away From Home Care Program. As a Guest Member, the Member's Guest Membership Benefits are provided by the local Blue Cross Plan participating in the Program. A 30 day notification period is required before Guest Membership Benefits under the Away From Home Care Program become available. Guest Membership is available for a limited period of time. The Away From Home Care Coordinator will confirm the period for which the Member is registered as a Guest Member.

Who is Eligible to Register for Guest Membership Benefits?

- The Member may register for Guest Membership Benefits when:
- The Member or the Member's Dependents temporarily travel outside Keystone's Service Area for at least 90 days, but no more than 180 days (long term traveler);
- The Member's Dependent student is attending a school outside Keystone's Service Area for more than ninety 90 days (student); or
- The Member's Dependent lives apart from the Member and is outside Keystone's Service Area for more than 90 days (families apart).

NOTE: The Member is required to contact the Away From Home Care Coordinator and apply for a Guest Membership by calling Customer Service at the telephone number shown on the ID Card. Notification must be given at least 30 days prior to the Member's scheduled date of departure in order for Guest Membership Benefits to be activated.

Student Guest Membership Benefits are available to qualified dependents of the Subscriber who are outside of the Keystone's Service Area temporarily attending an accredited education facility inside the service area of a Host HMO. Contact the Away From Home Care Coordinator by calling the Customer Service number on the ID card to determine if arrangements can be made for Student Guest Membership Benefits for the Member's Dependent.

The Away From Home Care Program provides Guest Membership Benefits coverage for a wide range of health care services including Hospital care, routine physician visits, and other services. Guest Membership Benefits are available only when the Member is registered as a Guest Member at a Host HMO. As a Guest Member, the Member is responsible for complying with all of the Host HMO's rules regarding access to care and Member responsibilities. The Host HMO will provide these rules and responsibilities at the time of guest membership registration.

NOTE: Because the Member's Primary Care Physician in the Keystone's Service Area

can give advice and provide recommendations about health care services that the Member may need while traveling, the Member is encouraged to receive routine or planned care prior to leaving home.

As a Guest Member, the Member must select a Primary Care Physician from the Host HMO's Primary Care Physician network. In order to receive Guest Membership Benefits, the Primary Care Physician in the Host HMO Service Area must provide or arrange for all of the Member's Covered Services while the Member is a Guest Member. Neither Keystone nor the Host HMO will cover services the Member receives as a Guest Member that are not provided or arranged by the Primary Care Physician in the Host HMO Service Area and Preapproved by the Host HMO. Registration in the Away From Home Care Program is available only through contracting HMOs in the Blue Cross and Blue Shield Association's HMO network. Information regarding the availability of Guest Membership Benefits may be obtained from the Away From Home Care Coordinator by calling Customer Service at the telephone number shown on the ID Card.

This Group's Program may contain other benefits that are not provided for Guest Members through the Away From Home Care Program. Benefits provided for Guest Members are in addition to benefits provided under Keystone's program. However, benefits provided under one program will not be duplicated under the other program. To receive benefits covered only by this program, the Member must contact Customer Service at the telephone number shown on the Member's ID Card. Further information will be provided about how to access these benefits.

WHEN THE MEMBER DOESN'T USE THE BLUECARD OR GUEST MEMBERSHIP PROGRAMS

If the Member has out-of-area Urgent Care or Emergency Services, not provided as described above and provided by a Non-Participating Provider, ask the Provider to submit the bill to Keystone. Show the Provider the Member ID Card for necessary information about the Member's Group plan. For direct billing, the Provider should mail the bill to the address in the next sentence. If direct billing cannot be arranged, send us a letter explaining the reason care was needed and an original itemized bill to:

Keystone Health Plan East
P.O. Box 898815
Camp Hill, PA 17089-8815.

It is the Member's responsibility to forward to Keystone any bill the Member receives for Emergency Services or out-of-area Urgent Care provided by a Non-Participating Provider.

CONTINUING CARE

Medically Necessary care provided by any Provider other than the Member's Primary Care Physician will be covered, subject to the ***Description Of Covered Services, Exclusions - What Is Not Covered***, and the ***Schedule Of Covered Services*** sections, only until the Member can, without medically harmful consequences, be transferred to the care of the Member's Primary Care Physician or a Referred Specialist designated by the Member's Primary Care Physician.

All continuing care must be provided or Referred by the Member's Primary Care Physician or coordinated through Customer Service.

AUTO OR WORK-RELATED ACCIDENTS

Motor Vehicle Accident

If the Member or the Member's Dependent is injured in a motor vehicle accident, contact the Member's or the Member's Dependent's Primary Care Physician as soon as possible.

REMEMBER: This Program will always be secondary to the Member's auto insurance coverage. However, in order for services to be covered by this Program as secondary, the Member's care must be provided or Referred by the Member's Primary Care Physician.

Tell the Member's Primary Care Physician that the Member was involved in a motor vehicle accident and the name and address of the Member's auto insurance company. Give this same information to any Provider to whom the Member's Primary Care Physician refers the Member for treatment.

Call Customer Service as soon as possible and advise us that the Member has been involved in a motor vehicle accident. This information helps this Health Benefit Plan to coordinate this Program's benefits with coverage provided through the Member's auto insurance company.

Only services provided or Referred by the Member's Primary Care Physician will be covered by this Program.

Work-Related Accident

Report any work-related injury to the Member's employer and contact the Member's Primary Care Physician as soon as possible.

REMEMBER: **This Program will always be secondary to the Member's Worker's Compensation coverage. However, in order for services to be covered by this Program as secondary, the Member's care must be provided or Referred by the Member's Primary Care Physician**.

Tell the Member's Primary Care Physician that the Member was involved in a work-related accident and the name and address of the Member's employer and any applicable information related to the Member's employer's Worker's Compensation coverage. Give this same information to any Provider to whom the Member's Primary Care Physician refers the Member for treatment.

Call Customer Service as soon as possible and advise us that the Member has been involved in a work-related accident. This information helps this Health Benefit Plan to coordinate this Program's benefits with coverage provided through the Member's employer's Worker's Compensation coverage.

Only services provided or Referred by the Member's Primary Care Physician will be covered by this Program.

EXCLUSIONS – WHAT IS NOT COVERED

Except as specifically provided in this Benefit Booklet, no benefits will be provided for services, supplies or charges:

Administration of Insulin

Any charges for the administration of injectable insulin.

Alternative Therapies/Complementary Medicine

For Alternative Therapies/complementary medicine, including but not limited to:

- Acupuncture;
- Music therapy;
- Dance therapy;
- Equestrian/hippotherapy;
- Homeopathy;
- Primal therapy;
- Rolfing;
- Psychodrama;
- Vitamin or other dietary supplements and therapy;
- Naturopathy;
- Hypnotherapy;
- Bioenergetic therapy;
- Qi Gong;
- Ayurvedic therapy;
- Aromatherapy;
- Massage therapy;
- Therapeutic touch;
- Recreational, wilderness, educational and sleep therapies.

Ambulance Services

For Ambulance services except as specifically provided under this Program.

Assisted Fertilization Techniques

For In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any services required in connection with these procedures.

Benefit Maximums

For charges Incurred for expenses in excess of benefit maximums as specified in the ***Schedule of Covered Services***.

Charges In Excess Of Covered Service For Insulin

Any charge where the usual and customary charge is less than the Member's Insulin or oral agent cost sharing amount.

Chronic Conditions

- For maintenance of chronic conditions, injuries or illness.
- For any Therapy service provided for:
  - Ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement ; and
  - Additional Therapy beyond this Program's limits, if any, shown on the ***Schedule of Covered Services***;
  - Work hardening;
  - Evaluations not associated with therapy; or
  - Therapy for back pain in pregnancy without specific medical conditions.

Cognitive Rehabilitation Therapy

For Cognitive Rehabilitation Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (For example: stroke, acute brain insult, encephalopathy).

Correctional Facility

- While a Member is incarcerated in any adult or juvenile penal or correctional facility or institution; or
- Care for conditions that federal, state or local law requires to be treated in a public facility.

Cosmetic Surgery

- For cosmetic Surgery, including cosmetic dental Surgery.
- Cosmetic Surgery is defined as any Surgery:
  - Done primarily to alter or improve the appearance of any portion of the body; and
  - From which no significant improvement in physiological function could be reasonably expected.

Regarding sagging skin: This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to:

- The eyelids;
- Face;
- Neck;
- Arms;
- Abdomen;
- Legs; or
- Buttocks.

Regarding enlargements, reductions and implantations: This exclusion also includes services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to:

- The ears;
- Lips;
- Chin; or
- Jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

Regarding bodily functions and deformities: This exclusion does not include those services performed when the patient is a Member of the Program and performed in order to restore bodily function or correct deformity resulting from:

- A disease;
- Recent trauma; or
- Previous therapeutic process.

Regarding birth defects: This exclusion does not apply to otherwise Covered Services necessary to correct:

- Medically diagnosed congenital defects for children and birth abnormalities for children.

Day Rehabilitation Program

For Day Rehabilitation Program services.

Dental Care (Medical)

- For dental services related to:
  - The care, filling, removal or replacement of teeth, including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta; and
  - The treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this Benefit Booklet.
  - Specific services not covered include, but are not limited to (unless otherwise described in this Benefit Booklet):

    - Apicoectomy (dental root resection);
    - Prophylaxis of any kind;
    - Root canal treatments;
    - Soft tissue impactions;
    - Alveolectomy;
    - Bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and
    - Treatment of Periodontal disease;

- For dental implants for any reason.
- For dentures, unless for the initial treatment of an Accidental Injury/trauma.
- For Orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.
- For injury as a result of chewing or biting (neither is considered an Accidental Injury).

Dental (Pediatric)

For Dental (Pediatric) as shown in the "Outpatient Services" section of the ***Description of Covered Services***:

- For services not specifically listed in the ***Schedule of Covered Services*** as a Covered Service.
- Provided to Members by Out-of-Network Dentists except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.
- Which, in the opinion of the treating dentist or the Health Benefit Plan, are:
  - Not clinically necessary; or
  - Do not have a reasonable, favorable prognosis.
- That are necessary:
  - Due to lack of cooperation with Primary Dental Office; or
  - Failure to comply with a professionally prescribed Treatment Plan.
- Started or Incurred prior to the Member's Effective Date of Coverage with the Health Benefit Plan; or started after the termination date of coverage with the Health Benefit Plan.
- For consultations by a Specialty Care Dentist for services not specifically listed on the ***Schedule of Covered Services*** as a Covered Service.
- For services or supplies that are not deemed generally accepted standards of dental treatment.
- That are the responsibility of:
  - Workers' Compensation;
  - Employer's liability insurance; or
  - For treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy.

The Health Benefit Plan's benefits would be in excess to the third party benefits and therefore, the Health Benefit Plan would have right of recovery for any benefits paid in excess.

- For services and/or appliances that alter the vertical dimension, including, but not limited to:
  - Full mouth rehabilitation;
  - Splinting;
  - Fillings to restore tooth structure lost from:
    - Attrition;
    - Erosion;
    - Abrasion;
    - Appliances;
    - Any other method.

  This exclusion does not apply if the dental condition is as a result of an accidental injury.
- For services that restore tooth structure due to attrition, erosion or abrasion.
- For periodontal splinting of teeth by any method.
- For replacement of:
  - Lost;
  - Missing;
  - Stolen; or
  - Damaged:
    - Prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
- For replacement of existing dentures that are, or can be made serviceable.
- For prosthetic reconstruction or other services which require a prosthodontist.
- For assistant at surgery.
- For elective procedures, including prophylactic extraction of third molars.
- For congenital mouth malformations or skeletal imbalances, including, but not limited to:
  - Treatment related to cleft palate;
  - Disharmony of facial bone; or
  - Required as the result of:
    - Orthognathic surgery, including orthodontic treatment;
    - Oral and maxillofacial services;
    - Associated Hospital and facility fees;
    - Anesthesia; and
    - Radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth.

  This exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including newly adoptive children, regardless of age.
- For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include but are not limited to such conditions as:
  - Temporomandibular joint disorder (TMD);
  - Craniomandibular disorders; or
  - Other conditions of the joint linking:
    - The jaw bone;
    - The complex of muscles, nerves and other tissues related to that joint.
- For implants;
  - Surgical insertion; and/or
  - Removal of, and any appliances and/or crowns attached to implants.
- For the following, which are not included as orthodontic benefits:

  - Retreatment of orthodontic cases;
  - Changes in orthodontic treatment necessitated by patient non-cooperation;
  - Repair of orthodontic appliances;
  - Replacement of lost or stolen appliances;
  - Special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders);
  - Myofunctional therapy;
  - Cases involving orthognathic surgery;
  - Extractions for orthodontic purposes; and
  - Treatment in excess of 24 months.
- For Prescription or nonprescription drugs, home care items, vitamins or dietary supplements.
- For hospitalization and associated costs for rendering services in a Hospital.
- For house or Hospital calls for dental services.
- For any dental or medical services:
  - Performed by a Physician; and/or services
  - Which benefits are otherwise provided under a health care plan of the employer.
- Which are Cosmetic in nature as determined by the Health Benefit Plan, including, but not limited to:
  - Bleaching, veneer facings;
  - Personalization or characterization of crowns;
  - Bridges and/or dentures.

  This exclusion does not apply for Cosmetic services required as the result of an accidental injury.
- For broken appointments.
- Arising from any intentionally self-inflicted injury or contusion when:
  - The injury is a consequence of the Member's commission of or attempt to commit a felony; or
  - Engagement in an illegal occupation; or
  - Because the Member is intoxicated or under the influence of illicit narcotics.
- For any condition caused by or resulting from:
  - Declared or undeclared war or act thereof; or
  - Resulting from service in the national guard or in the armed forces of any country or international authority.
- Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by the Health Benefit Plan.

  Orthodontic services for the following are excluded:
  - Treatments that are primarily for Cosmetic reasons;
  - Treatments for congenital mouth malformations or skeletal imbalances (For example, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment);
  - Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the ***Schedule of Covered Services***. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

  Orthodontia procedures will only be approved for:

- Dentofacial abnormalities that severely compromise the Member's physical health; or
- A serious handicapping malocclusion.

Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables:
- Degree of malalignment;
- Missing teeth;
- Angle classification;
- Overjet and overbite;
- Open bite and crossbite.

The determination will be made by the Dentist in accordance with guidelines established by the Health Benefit Plan.

When there is a conflict of opinion on whether or not a dental service or procedure is Medically Necessary between the:
- Dentist; and
- Health Benefit Plan;

The opinion of the Health Benefit Plan will be final.

Drugs That May Be Dispensed Without A Doctor's Prescription

- For drugs and other medications:
- Outpatient Prescription Drugs, except if covered by the Prescription Drug benefit; and, Medications that may be dispensed without a doctor's prescription.

This exclusion does not apply for coverage of insulin and oral agents used for the treatment of diabetes.

Durable Medical Equipment

The following, with respect to Durable Medical Equipment (DME): Equipment for which any of the following statements are true is not DME and will not be covered. This includes any item:

- That is for comfort or convenience: Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps, and telephone alert systems; bed-wetting alarms; and, ramps.
- That is for environmental control: Items not covered include, but are not limited to: air cleaners; air conditioners; dehumidifiers; portable room heaters; customized wheelchairs and ambient heating and cooling equipment.
- That is inappropriate for home use: This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes.
- That is a non-reusable supply or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function. This means the equipment is not durable or is not a component of the DME. Items not covered include, but are not limited to:
  - Incontinence pads;
  - Lamb's wool pads;
  - Ace bandage;
  - Catheters (non-urinary);
  - Face masks (surgical);
  - Disposable gloves;
  - Sheets and bags; and
  - Irrigating kit.
- That is not primarily medical in nature: Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered medical equipment. This is true

even though the item has some remote medically related use. Items not covered include, but are not limited to:

- Ear plugs;
- Exercise equipment;
- Ice pack;
- Speech teaching machines;
- Strollers;
- Silverware/utensils;
- Feeding chairs;
- Toileting systems;
- Toilet seats;
- Bathtub lifts;
- Elevators;
- Stair glides; and
- Electronically-controlled heating and cooling units for pain relief.

- That has features of a medical nature which are not required by the patient's condition, such as a gait trainer: The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists: A Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.
- That duplicates or supplements existing equipment for use when traveling or for an additional residence: For example: A patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would NOT be eligible for two identical items, or one for each living space.
- Which is not customarily billed for by the Provider: Items not covered include, but are not limited to delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.
- That modifies vehicles, dwellings, and other structures: This includes any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability; or to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
- Equipment for safety: Items that are not primarily used for the diagnosis, care or treatment of disease or injury but are primarily utilized to prevent injury or provide a safe surrounding. Examples include:
  - Restraints;
  - Safety straps;
  - Safety enclosures; or
  - Car seats.

The Health Benefit Plan will neither replace nor repair the DME due to abuse or loss of the item.

Effective Date

Which were Incurred prior to the Member's Effective Date of coverage.

Experimental/Investigative

Services and supplies which are Experimental/Investigative in nature, except:

- Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Benefit Booklet; and
- As Preapproved by the Health Benefit Plan.

Routine patient costs do not include any of the following:

- The investigational item, device, or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Foot Care

For foot care to make feet feel better or look better, including treatment for:

- Bunions (EXCEPT: capsular or bone Surgery);
- Toenails (EXCEPT: Surgery for ingrown nails);
- Subluxations of the foot;
- Corns;
- Calluses;
- Fallen arches;
- Pes planus (flat feet);
- Weak feet;
- Chronic foot strain; or
- Other routine podiatry care.

Unless they are:

- Associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes; and
- Deemed Medically Necessary by the Members Primary Care Physician, specialist or the Health Benefit Plan.

Foot Orthotics

For supportive devices for the foot (orthotics), such as, but not limited to:

- Foot inserts;
- Arch supports;
- Heel pads and heel cups; and
- Orthopedic/corrective shoes.

This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes.

Health foods and Dietary Supplements

For health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents.

Hearing Aids

For hearing or audiometric examinations, and Hearing Aids including cochlear electromagnetic hearing devices and the fitting thereof; and, routine hearing examinations. Services and supplies related to these items are not covered.

High Cost Technical Equipment

For equipment costs related to services performed on high cost technological equipment unless the acquisition of such equipment was approved through a Certificate of Need process and/or the Health Benefit Plan.

Home Blood Pressure Machines

For Home blood pressure machines, except for Members:

- With pregnancy-induced hypertension;
- With hypertension complicated by pregnancy; and
- With end-stage renal disease receiving home dialysis.

Home Health Care

For Home Health Care services and supplies in connection with Home Health services for the following:

- Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;

- Rental or purchase of Durable Medical Equipment;
- Rental or purchase of medical appliances (For example, braces) and Prosthetic Devices (For example, artificial limbs); supportive environmental materials and equipment, such as:
  - Handrails;
  - Ramps;
  - Telephones;
  - Air conditioners and similar services;
  - Appliances; and;
  - Devices;
- Prescription Drugs
- Provided by family members, relatives, and friends;
- A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
- Emergency or non-Emergency Ambulance services;
- Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
- Visits by any Provider personnel solely for the purpose of assessing a Member's condition and determining whether or not the Member requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

Hospice Care

Hospice Care benefits for the following:
- Research studies directed to life lengthening methods of treatment;
- Services or expenses Incurred in regard to the Member's personal, legal and financial affairs (such as preparation and execution of a will or other disposition of personal and real property); and
- Private Duty Nursing.

Immediate Family

Rendered by a member of the Member's Immediate Family.

Immunizations for Employment or Travel

Immunizations required for employment purposes or travel. This exclusion does not apply to Immunizations required for travel which are required by the Advisory Committee on Immunization Practices (ACIP).

Injectable Medications

Injectable medications except those necessary for the immediate treatment of an injury or acute illness when provided or Referred by the Members Primary Care Physician and administered in the Physician's office.

Medical Foods And Nutritional Formulas

For amino acid supplements, non-elemental formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (For example, Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the ***Description of Covered Services***.

Medical Supplies

For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.

Medical Necessity or Referred

- Not provided by or Referred by the Member's Primary Care Physician except in an Emergency or as specified elsewhere in this Benefit Booklet; and
- Which are not Medically Necessary, as determined by the Primary Care Physician or the Health Benefits Plan, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under the Health Benefit Plan and described in this Benefit Booklet.

Mental Illness and Alcohol Or Drug Abuse And Dependency

- For any Mental Health Care, Serious Mental Illness Health Care, or Alcohol Or Drug Abuse And Dependency modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as: Alternative Therapies/Complementary Medicine and obesity control therapy except as otherwise provided in this Program;
- Non-medical services, such as vocational rehabilitation or employment counseling, for the treatment of Alcohol or Drug Abuse and Dependency in an acute care Hospital.

Military Service

For any loss sustained or expenses Incurred in the following ways:

- During military service while on active duty as a member of the armed forces of any nation; or
- As a result of enemy action or act of war, whether declared or undeclared.

Miscellaneous

Charges for:

- For care in a :
  - Nursing home;
  - Home for the aged;
  - Convalescent home;
  - School;
  - Camp;
  - Institution for intellectually disabled children; or
  - Custodial Care in a Skilled Nursing Facility;
- For broken appointments;
- For marriage or religious counseling;
- For completion of any insurance forms.
- For Custodial Care, or domiciliary care;
- For residential care;
- For charges not billed/performed by a Provider.
- For additional treatment necessitated by lack of patient cooperation or failure to follow a Prescribed Plan Of Treatment;
- For services for which the cost is later recovered through legal action, compromise, or claim settlement;
- For protective and supportive care, including educational services, rest cures and convalescent care

- Performed by a Professional Provider enrolled in an education or training program when such services are:
  - Related to the education or training program; and are
  - Provided through a Hospital or university.
- For weight reduction and premarital blood tests. This exclusion does not apply to nutrition visits as set forth in the ***Description of Covered Services*** section under the subsection entitled "Nutrition Counseling for Weight Management"***.***

Motor Vehicle Accident

For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is:

- Paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan; or
- Payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.

Non-Covered Services

For any services, supplies or treatments not specifically listed as covered benefits in this Program.
Note: The Health Benefit Plan reserves the right:

- To specify Providers of, or means of delivery of Covered Services, supplies or treatments under this Program and
- To substitute such Providers or sources where medically appropriate.

EXCEPTIONS - No benefits are provided for the above, unless:
The unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health.

Non-Traditional Care of Mental Health Disorders and Alcohol Or Drug Abuse And Dependency

For any treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, for:

- Mental Health Care;
- Serious Mental Illness Health Care; or
- Alcohol Or Drug Abuse And Dependency.

For example:

- Alternative Therapies/Complementary Medicine; and
- Obesity control therapy.

No benefits are provided for the above, except as otherwise provided in this Program.

Obesity

For treatment of obesity, including surgical treatment of obesity.

This exclusion does not apply to nutrition counseling visits/sessions as described in the "Nutrition Counseling for Weight Management" provision in this Benefit Booklet.

Organ Donation

Services required by a Member donor related to organ donation. Expenses for donors donating organs to Member recipients are covered only as provided in this Program and described in this

Benefit Booklet. No payment will be made for human organs which are sold rather than donated.

Orthoptic/Pleoptic Therapy
Services related to Orthoptic/Pleoptic Therapy.

Personal Hygiene and Convenience Items

For personal hygiene and convenience items such as, but not limited to the following, whether or not recommended by a Provider:

- Air conditioners;
- Humidifiers;
- Physical fitness or exercise equipment;
- Radio;
- Beauty/barber shop services;
- Guest trays;
- Chairlifts;
- Stairglides;
- Elevators;
- Spa or health club memberships;
- Whirlpool;
- Sauna;
- Television;
- Telephone;
- Guest Service; or
- Hot tub or equivalent device.

Physical Examinations

For routine physical examinations for non-preventive purposes, such as:

- Pre-marital examinations;
- Physicals for college
- Camp or travel; and
- Examinations for insurance, licensing and employment.

Prescription Drugs (Drug Program)

- Devices of any type, even though such devices may require a Prescription Order Or Refill. This includes, but is not limited to, therapeutic devices or appliances, hypodermic needles, syringes or similar devices, support garments or other devices, regardless of their intended use, except as specified as a benefit in Program. This exclusion does not apply to:
  - Devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and
  - Devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicine; or
  - Contraceptive devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
- Drugs Prescribed and administered in the Physician's office;
- Drugs for which there is an equivalent that does not require a Prescription Order, (For example, over-the-counter medicines) whether or not prescribed by a physician. This exclusion does not apply to:
  - Insulin or over-the-counter drugs that are prescribed by a physician in accordance with applicable law; or
  - Certain over-the-counter drugs as mandated by the Patient Protection and Affordability Act.
- Any drugs already listed as covered in the Member's Benefit Booklet;
- Prescription Drugs covered without charge under Federal, State or local programs including Worker's Compensation and Occupational Disease laws;
- Medication for a Member confined to a rest home, Skilled Nursing Facility, sanitarium, extended care facility, Hospital or similar entity;

- Medication furnished by any other medical service for which no charge is made to the Member;
- Covered Drugs Or Supplies administered at the time and place of the Prescription Order;
- Any charges for the administration of Prescription Legend Drugs or injectable insulin;
- Prescription Drugs dispensed by Non-Participating Pharmacies, except as specified in the ***Outpatient Services*** section of this Benefit Booklet;
- Prescription Refills resulting from loss or theft, or any unauthorized Refills;
- Immunization agents, biological sera, blood or plasma, or allergy serum;
- Experimental Or Investigational Drugs, and drugs Prescribed for experimental (non-Food and Drug Administration approved) indications;
- Drugs used for cosmetic purposes, including but not limited to, anabolic steroids, minoxidil lotion, and Retin A (tretinoin), when used for non-acne related conditions. However, this exclusion does not include drugs prescribed to treat medically diagnosed congenital defects and birth abnormalities;
- Pharmacological therapy for weight reduction or diet agents unless Preapproved by the Health Benefit Plan;
- Any charge where the usual and customary charge is less than the Member's Prescription Drug cost sharing;
- Injectable drugs including injectable drugs used for the primary purpose of treating infertility or injectable drugs for fertilization. This exclusion does not include injectable Contraceptive Drugs or injectables that are otherwise not covered under the Program.
- Prescription Drugs not approved by the Health Benefit Plan or Prescribed drug amounts exceeding the quantity level limits as conveyed by the Food and Drug Administration (FDA) or the Health Benefit Plan's Pharmacy and Therapeutics Committee;
- Specialty Drugs that are not purchased through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program. This exclusion does not apply to Insulin.

Prescription Drugs (Medical Program)

- For Prescription Drugs, except as may be provided under the "Prescription Drugs" section of the ***Description of Covered Service*****s**. This exclusion does NOT apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels, as provided for the treatment of diabetes.
- For drugs and medicines for which the Member has coverage under a free-standing prescription drug program provided through the enrolled Group.

Private Duty Nursing

- For Inpatient or Outpatient Private Duty Nursing services.

Prosthetic Device Repair and Replacement Due to Misuse

For services for repairs or replacements of Prosthetic Devices needed because the prosthesis was abused or misplaced.

Relative Counseling or Consultations

For counseling or consultation with a Member's relatives, or Hospital charges for a Member's relatives or guests, except as may be specifically provided or allowed in the "Treatment for Alcohol Or Drug Abuse And Dependency" or "Transplant Services" sections of the ***Description of Covered Service*****s**.

Responsibility of Another Party

- For which a Member would have no legal obligation to pay, or another party has primary responsibility.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

Responsibility of Medicare

Paid or payable by Medicare when Medicare is primary. For purposes of this Program, a service, supply or charge is “payable under Medicare” when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits.

Reversal of a Sterilization

For any Surgery performed for the reversal of a sterilization and services required in connection with such procedures.

Self-Administered Prescription Drugs

For Self-Administered Prescription Drugs, under the Member's medical benefit, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered Self-Administered Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration.

- This exclusion does not apply to Self- Administered Prescription Drugs that are:
- Covered under the "Prescription Drugs" section of the ***Description of Covered Service*s**;
- Mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by a Prescription Drug benefit or free-standing prescription drug contract issued by the Health Benefit Plan or its affiliates; or
- Required for treatment of an Emergency condition that requires a Self- Administered Prescription Drug.

Services Not Performed By a Designated Provider

The following Outpatient services that are not performed by the Member’s Primary Care Physician’s Designated Provider, when required under the plan:

- Rehabilitation Therapy Services: (other than Speech Therapy);
- Diagnostic radiology services: If the Member is age five (5) or older; and
- Laboratory and Pathology Tests.

EXCEPTIONS - No benefits are provided for the above, unless Preapproved by the Health Benefit Plan.

Services with No Charge

Medication furnished by any other medical service for which no charge is made to the Member.

Sexual Dysfunction

For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury.

Skilled Nursing Facility

For Skilled Nursing Facility services in connection with the following:

- When confinement is intended solely to assist the Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
- For the treatment of Alcohol And Drug Abuse Or Dependency, and Mental Illness; or
- After the Member has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care.

Temporomandibular Joint Syndrome (TMJ)

For oral devices used for the treatment of temporomandibular joint syndrome (TMJ) or dysfunction.

Termination Date

Which were or are Incurred after the date of termination of the Member's coverage except as provided in the ***General Information*** section.

Traditional Medical Management

For any care that extends beyond traditional medical management for:

- Autistic disease of childhood;
- Pervasive Developmental Disorders;
- Attention Deficit Disorder;
- Learning disabilities;
- Behavioral problems;
- Intellectual disability; or
- Treatment or care to effect environmental or social change;

Except as otherwise provided in this program.

Transsexual Surgery

For any procedure or treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery.

Veteran's Administration or Department of Defense

To the extent a Member is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Member.

Vision Care (Medical)

Vision care, including but not limited to:

- All surgical procedures performed solely to eliminate the need for or reduce the Prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty;
- Lenses which do not require a Prescription;
- Any lens customization such as, but not limited to tinting, oversize or progressive lenses; antireflective coatings, U-V lenses or coatings, scratch resistant coatings, mirror coatings, or polarization;
- Deluxe frames; or
- Eyeglass accessories such as cases, cleaning solution and equipment.
- For eyeglasses, lenses or contact lenses and the vision examination for Prescribing or fitting eyeglasses; or

- Routine Vision exams except as otherwise described in this Benefit Booklet.

Weight Reduction

For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary. This exclusion does not apply to the Health Benefit Plan's weight reduction program nutrition counseling visits/sessions as described in the "Nutrition Counseling for Weight Management" provision in this Benefit Booklet.

Wigs

For wigs and other items intended to replace hair loss due to male/female pattern baldness or due to illness or injury including but not limited to injury due to traumatic or surgical scalp avulsion, burns, or Chemotherapy.

Worker's Compensation

For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of:

- Worker's Compensation Law; or
- Any similar Occupational Disease Law or Act.

This exclusion applies whether or not the Member claims the benefits or compensation.

GENERAL INFORMATION

ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THIS PROGRAM

The Member's Group benefits administrator is responsible for maintaining eligibility of Members to receive benefits under this Program and for timely notifying the Health Benefit Plan of such eligibility. The Health Benefit Plan will provide coverage, and terminate coverage, in reliance on the Group's timely notification of the eligibility of Members. If a Group fails to timely notify the Health Benefit Plan of the eligibility status of a particular Member, the Health Benefit Plan will provide and terminate coverage in accordance with any Health Benefit Plan administrative processes.

ELIGIBILITY

Eligible Subscriber

An eligible Subscriber is an individual who is listed on the completed Enrollment/Change Form provided by the Health Benefit Plan and:

- Who resides or, with approval from the Health Benefit Plan, works in the Service Area; and
- Who is an active Employee whose normal work week is defined by the Group or is an eligible retiree; and
- Who is entitled to participate in the Group's health benefits program, including compliance with any probationary or waiting period established by the Group or who is entitled to coverage under a trust agreement or employment contract; and
- For whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling.

Group Election

A Group that elects to make Dependent coverage available under the Program may choose to make coverage available for all eligible Dependents, as defined below or may choose to make coverage available only for Dependent children. If the Group limits Dependent coverage to Dependent children, the term 'Dependent' as used in this Program is limited to Dependent children.

Eligible Dependent

An eligible Dependent is an individual for whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling; who resides in the Service Area, unless otherwise provided in this section; who meets all the eligibility requirements established by the Group; who is listed on the Enrollment/Change Form completed by the Subscriber; and who is:

- The Subscriber's legal spouse or Domestic Partner, if applicable; or
- A child (including stepchild, legally adopted child, child placed for adoption, or natural child) of either the Subscriber, the Subscriber's spouse, or the Domestic Partner's (if applicable), who is within the Limiting Age for Dependents as set forth in this Program, or a child for whom the Subscriber is legally required to provide health care coverage; or
- A child for whom the Subscriber or the Subscriber's spouse is a court appointed legal guardian; or
- A child , regardless of age, who, in the judgment of the Health Benefit Plan, is incapable of self-support due to a mental or physical handicap which commenced prior to the child's reaching the Limiting Age for Dependents under this Program and for which continuing justification may be required by the Health Benefit Plan; or
- A child within the Limiting Age for Dependents under this Program who resides in the Service Area; or
- A child who is past the Limiting Age for Dependents will be eligible when they:
  - Are a full-time student;

- Are eligible for coverage under this Program;
- Prior to attaining the Limiting Age for Dependents and while a full-time student, were:
  - A member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and were called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or,
  - A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

  Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

  As proof of eligibility, the Subscriber must submit a form to the Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):
  - Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
  - Notifying the Health Benefit Plan that the Dependent is no longer on active duty; and,
  - Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after his release from active duty.
- A Dependent of a Subscriber who is enrolled in a HMO Medicare risk program. A Dependent child of such Subscriber must be within the Limiting Age for Dependents under this Program;
- The newborn child of a Member for the first 31 days immediately following birth. Coverage will continue in effect thereafter if the newborn qualifies as a Dependent, is enrolled by the Subscriber within 31 days of birth, and any appropriate payment due, calculated from the date of birth, is received by the Health Benefit Plan; or

- An adopted child of a Member for the first 31 days immediately following:
  - Birth, if a newborn or,
  - The date of placement for adoption, if not a newborn. Coverage will continue in effect thereafter if the adopted child qualifies as a Dependent, is enrolled by the Subscriber within 31 days of birth, if a newborn, or otherwise, the placement date, and any appropriate payment due, calculated from the date of birth or placement, is received by the Health Benefit Plan.

Under this Program no other benefits, except conversion privileges, will be extended to the newborn child of a Dependent unless such newborn child meets the eligibility requirements of a Dependent set forth in this section and is enrolled as a Dependent within 31 days of eligibility.

Note: If the Group elects to limit coverage to Dependent children, the term Dependent excludes a legal spouse and Domestic Partner.

Over-Age Dependent Coverage Under This Program (If Applicable)

- Eligible Dependents
  For an adult Dependent child to qualify for Over-Age Dependent Coverage, in addition to the coverage being provided at the option of the group, the adult Dependent child must:
  - Have reached the Limiting Age for Dependents, but is less than 30 years of age;
  - Not be married;
  - Have no Dependents;
  - Be a resident of the Commonwealth of Pennsylvania or be a full-time student in an institution of higher education;
  - Not be a subscriber or insured of any other group or individual health insurance policy; and
  - Not be entitled to benefits under any government program.
- When Over-Ager Dependent Coverage Ends
  An Over-Age Dependent's continued group health benefits end on the first of the following:
  - The date the Over-Age Dependent:
    - Attains age 30;
    - Marries;
    - Acquires a Dependent;
    - Is no longer either a resident of the Commonwealth of Pennsylvania or enrolled as a full-time student at an Accredited Educational Institution; or
    - Becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.

The provisions shown above do not apply to Vision Care and Dental (Pediatric) coverage.

EFFECTIVE DATE OF COVERAGE

Subject to the receipt of applicable payments from the Group, and of an Enrollment/Change Form from or on behalf of each prospective Member, and subject to the provisions of this Program, coverage for Members under this Program shall become effective on the earliest of the following dates:

- When an eligible person makes written application for membership on or prior to the date on which eligibility requirements under this section are satisfied, coverage shall be effective as of the date the eligibility requirements are satisfied; or
- When an eligible person makes written application for membership after the date on which the eligibility requirements of this section are satisfied, but within 30 days after becoming eligible, coverage will be effective as of the date the eligibility requirements are satisfied; or
- Coverage shall become effective at birth for newborn children for 31 days. Coverage will continue in effect thereafter if the newborn qualifies as a Dependent, is enrolled by the Subscriber within 31 days of birth, and any appropriate payment, calculated from the date of birth, is received by the Health Benefit Plan; or
- Coverage for an adopted child shall become effective at birth, if a newborn, and otherwise on the date of placement, for 31 days. Coverage will continue in effect thereafter if the adopted child qualifies as a Dependent, is enrolled by the Subscriber within 31 days of:
  - Birth, if a newborn or
  - If not a newborn, the date of placement, and any appropriate payment, calculated from the date of:
    - birth, if a newborn or
    - placement, if not a newborn, is received by the Health Benefit Plan; or
- When an eligible person makes written application for membership during the Group Open Enrollment Period, coverage will begin on the first day of the calendar month following the conclusion of the Group Open Enrollment Period, unless otherwise agreed to by the Group

and the Health Benefit Plan.

If on the date on which coverage under the Program becomes effective, the Member is receiving Inpatient Care, benefits will be provided under this Program to the extent that such benefits are not provided under a prior group health insurance plan.

WHEN TO NOTIFY THE PROGRAM OF A CHANGE

Certain changes in a Member's life may affect their coverage under this Program. Please notify us of any changes through the benefits office of the Member's Group benefits administrator. To help the Health Benefit Plan effectively administer Members' health care benefits, the Health Benefit Plan should be notified of the following changes within 30 days: name; address; status or number of Dependents; marital status; eligibility for Medicare coverage, or any other changes in eligibility.

Open Enrollment

The Member's Group benefits administrator will have an open enrollment period at least once a year, and will notify the Member of the time. At this time, the Member may add eligible Dependents to their coverage.

Newly Hired

Within 30 days of becoming eligible for this new Group's coverage, an individual may join this Program. The Member must add existing eligible Dependents to their coverage at this time or wait until the next open enrollment period.

Late Enrollment

If an individual or an individual's Dependent did not request enrollment for coverage with this Program during the initial enrollment period and did not enroll within 30 days of the date during which the individual was first eligible to enroll under this Program, the individual may apply for coverage as a late Subscriber.

Marriage

Members may add their spouse to their Program within 30 days of their marriage. Coverage for a Member's spouse will be effective on the date of their marriage.

New Child

Coverage is effective at the time of birth for the newborn child of a Member, or at the time of placement for adoption for an adopted child of a Member, and shall continue for a period of 31 days after the event. If a Member chooses to continue coverage for the new child, the Member must add their eligible child (newborn or adopted child) within 31 days of the date of birth or placement of the adopted child. Coverage will be effective from the date of birth or the day the child was placed for adoption.

In situations where the newborn's father is a Member but the mother is not a Member, Customer Service must be notified prior to the mother's hospitalization for delivery.

Court-Ordered Dependent Coverage

If a Member is required by a court order to provide health care coverage for their eligible Dependent, their Dependent will be enrolled within 30 days from the date the Health Benefit Plan receives notification and a copy of the court order.

REMEMBER: The Member must notify the Health Benefit Plan of any changes to Dependent coverage within 30 days of the change in order to ensure coverage for all eligible family members. Notifications to the Health Benefit Plan should be through the benefits office of their Group benefits administrator.

TERMINATION OF COVERAGE

A Member's coverage may be cancelled under the following conditions:

- If the Member commits intentional misrepresentation of a material fact or fraud in applying for or obtaining coverage from this Program (subject to their rights under the ***Complaint and Grievance Appeal Process***);
- If a Member misuses their ID Card, or allows someone other than their eligible Dependents to use a ID Card to receive care or benefits;
- If a Member ceases to meet the eligibility requirements;
- The Member's Group terminates coverage with this Program;
- If the Member displays a pattern of non-compliance with their Physician's Plan Of Treatment. The Member will receive written notice at least 30 days prior to termination. The Member has the right to utilize the ***Complaint and Grievance Appeal Process***; or
- If the Member does not cooperate with the Health Benefit Plan in obtaining information necessary to determine this Health Benefit Plan's liability under this Program.

Inpatient Provision upon Termination of Coverage

If a Member is receiving Inpatient Care in a Hospital or Skilled Nursing Facility on the day this coverage is terminated by the Health Benefit Plan, except for termination due to fraud or intentional misrepresentation of a material fact, the benefits shall be provided until the earliest of:

- The expiration of such benefits according to the ***Schedule of Covered Services*** included with this Benefit Booklet;
- Determination of the Primary Care Physician and the Health Benefit Plan that Inpatient Care is no longer Medically Necessary; or
- The Member's discharge from the facility.

NOTE: The Health Benefit Plan will not terminate the Member's coverage because of their health status, their need for Medically Necessary Covered Services or for having exercised their rights under the ***Complaint and Grievance Appeal Process***.

When a Subscriber’s coverage terminates for any reason, coverage of the Subscriber’s covered family members will also terminate.

Termination of Coverage at Termination of Employment or Membership in the Group

Coverage for the Member under this Program will terminate on the date specified by the Group if the Health Benefit Plan receives from the Group notice of termination of the Member's coverage within 30 days of the date specified by the Group. If notification from the Group is not received by the Health Benefit Plan within 30 days of the date specified by the Group, the effective date of termination of the Member’s coverage shall be 30 days prior to the first day of the month in which the Health Benefit Plan received the notice of termination of the Member’s coverage from the Group, with the exception of any services covered under the Inpatient Provision. If the Member is receiving Inpatient Care on the date coverage is terminated, the Inpatient Provision will apply as defined above. Coverage for Dependents ends when the Member's coverage ends.

COVERAGE CONTINUATION

When The Employee Terminates Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or eligible Dependent to temporarily extend health care coverage.

Continuation Of Coverage Pennsylvania Act 62 of 2009 (Mini-COBRA)

This subsection, and the requirements of Mini-COBRA continuation, applies to Groups consisting of two to 19 employees. This provision applies when the Subscriber is an eligible employee of the Group.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify him or her for continuation under this subsection, has been covered continuously for benefits under this Program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:

- The Subscriber;
- The Subscriber's Dependent spouse; or
- The Subscriber's Dependent child.

In addition, any child born to or placed for adoption with the Subscriber during Mini-COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Program during Mini-COBRA continuation, other than a child born to or placed for adoption with the Subscriber during Mini-COBRA continuation, will not be a qualified beneficiary.

- If the Subscriber Terminates Employment or Has a Reduction of Work Hours: If the Subscriber's group benefits end due to his/her termination of employment or reduction of work hours, the Subscriber may be eligible to continue such benefits for up to nine months, if:
  - The Subscriber's termination of employment was not due to gross misconduct;
  - The Subscriber is not eligible for coverage under Medicare;
  - The Subscriber verifies he/she is not eligible for group health benefits as an eligible dependent; and
  - The Subscriber is not eligible for group health benefits with any other carrier.

The continuation will cover the Subscriber and any other qualified beneficiary who loses coverage because of the Subscriber's termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the "When Continuation Ends" paragraph of this subsection.

- The Group's Responsibilities: The Group must notify the Subscriber, the benefits administrator, and the Health Benefit Plan, in writing, of:
  - The Subscriber's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
  - The Subscriber's death;
  - The Subscriber's divorce or legal separation from a Dependent spouse covered under this Program;

- The Subscriber becoming eligible for benefits under Social Security;
- The Subscriber's child ceasing to be a Dependent child pursuant to the terms of this Program;
- Commencement of the Group's bankruptcy proceedings.

The notice must be given to the Subscriber, the benefits administrator and the Health Benefit Plan no later than 30 days of any of these events.

- The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the benefits administrator or its designee of their election of continuation coverage within 30 days of receipt of the Notice from the Group.

Continuation coverage shall be effective as of the date of the event.

Upon receipt of the Subscriber's, or the Subscriber's covered Dependent's election of continuation coverage, the benefits administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

- If the Subscriber Dies: If the Subscriber dies, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If the Subscriber's Marriage Ends: If the Subscriber's marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If a Dependent Loses Eligibility: If the Subscriber's Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Program, other than the Subscriber's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the benefits administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of his or her continuation rights from the benefits administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Group must notify the Health Benefit Plan of the qualified beneficiary's election of continuation within 14 days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the benefits administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the benefits administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this Program on a regular basis. It includes any amount that would have been paid by the Group. An additional administrative

charge of up to five percent of the total premium charge may also be required by the Health Benefit Plan.

- Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

- When Continuation Ends: A qualified beneficiary's continued group health benefits under this Program's ends on the first to occur of the following:
  - With respect to continuation upon the Subscriber's termination of employment or reduction of work hours, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to continuation upon the Subscriber's death, the Subscriber's legal divorce or legal separation, or the end of the Subscriber's covered Dependent's eligibility, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to the Subscriber's Dependent whose continuation is extended due to the Subscriber's entitlement to Medicare, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - The date coverage under this Program ends;
  - The end of the period for which the last premium payment is made;
  - The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
  - The date the Subscriber and/or the Subscriber's eligible dependent become eligible for Medicare.

THE HEALTH BENEFIT PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER MINI-COBRA ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION.

THE HEALTH BENEFIT PLAN IS NOT THE BENEFITS ADMINISTRATOR OR PLAN ADMINISTRATOR UNDER THIS PROGRAM OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS BENEFITS ADMINISTRATOR OR PLAN ADMINISTRATOR, THE BENEFITS ADMINISTRATOR OR PLAN ADMINISTRATOR SHALL BE THE GROUP.

Conversion

If a Member or their Dependents become ineligible for coverage through their Group Program, they may apply for continuation of coverage in an appropriate non-group program. The Member must reside in Keystone's five county area in order to be eligible for the non-group HMO program. The five county area includes: Bucks, Chester, Delaware, Montgomery and Philadelphia counties. If the Member does not live in Keystone's five county area, enrollment in the HMO non-group program is provided to the Member and their Dependents for 90 days from the date the Member's Group coverage ends. After this time period, the Member and their Dependents will have to convert to another plan. The Member and their Dependents may convert to the local Blue Cross®/Blue Shield® plan for the area in which they live.

A Member's application for this conversion coverage must be made to the Health Benefit Plan within 30 days of when the Member becomes ineligible for Group coverage. The benefits provided under the available non-group program may not be identical to the benefits under their Group Program.

The conversion privilege is available to Members and:
- Their surviving Dependents, in the event of the Member's death;
- Their spouse, in the event of divorce; or
- Their child who has reached the Limiting Age for Dependents.

The Dependent must reside in Keystone's five county area in order to be eligible for the non-group HMO program.

This conversion privilege is not available if the Member is terminated by the Health Benefit Plan for cause (such as deliberate misuse of an ID Card, significant misrepresentation of information that is given to the Health Benefit Plan or a Provider, or fraud).

If the Member needs more information regarding their conversion privilege, call Customer Services at the telephone number shown on their ID Card.

Should the Member choose continued coverage under COBRA (see above), they become eligible to convert to an individual, non-group plan at the end of the Member's COBRA coverage.

A SUMMARY OF THE PROGRAM'S FEATURES

Required Disclosure Of Information

State law requires that the Health Benefit Plan make the following information available to the Member when they make a request in writing to the Health Benefit Plan.
- A list of the names, business addresses and official positions of the membership of the Board of Directors or Officers of the Health Benefit Plan.
- The procedures adopted to protect the confidentiality of medical records and other Subscriber information.
- A description of the credentialing process for health care Providers.
- A list of the participating health care Providers affiliated with participating Hospitals.
- Whether a specifically identified drug is included or excluded from coverage.
- A description of the process by which a health care Provider can Prescribe any of the following when either:
  - The Drug Formulary's equivalent has been ineffective in the treatment of the Subscriber's disease; or
  - The drug causes or is reasonably expected to cause adverse or harmful reactions to the Subscriber.
    - Specific drugs;
    - Drugs used for an off-label purpose; and
    - Biologicals and medications not included in the Drug Formulary for Prescription Drugs or biologicals.
- A description of the procedures followed by the Health Benefit Plan to make decisions about the experimental nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by the Health Benefit Plan to reimburse for health care services. (This does not mean that the Health Benefit Plan is required to disclose

individual contracts or the specific details of financial arrangements we have with health care Providers.)
- A description of the procedures used in the Health Benefit Plan's quality assurance program.
- Other information the Pennsylvania Department of Health or Insurance Department may require.

Confidentiality And Disclosure Of Medical Information
The Health Benefit Plan's privacy practices, as they apply to Members enrolled in this Program, as well as a description of Members' rights to access their personal health information which may be maintained by the Health Benefit Plan, are set forth in the Health Benefit Plan's HIPAA Notice of Privacy Practices (the "Notice"). The Notice is sent to each new Member upon initial enrollment in this Program, and, subsequently, to all Members if and when the Notice is revised.

By enrolling in this Program, Members give consent to the Health Benefit Plan to receive, use, maintain, and/or release their medical records, claims-related information, health and related information for the purposes identified in the Notice to the extent permitted by applicable law. However, in certain circumstances, which are more fully described in the Notice, a specific Member Authorization may be required prior to the Health Benefit Plan's use or disclosure of Members' personal health information. Members should consult the Notice for detailed information regarding their privacy rights.

Member Id Card

Listed below are some important things to do and to remember about the Member's ID Card:
- Check the information on the Member's ID Card for completeness and accuracy.
- Check that the Member received one ID Card for each enrolled family member.
- Check that the name of the Primary Care Physician (or office) the Member selected is shown on the Member's ID Card. Also, please check the ID Card for each family member to be sure the information on it is accurate.
- Call Customer Service if the Member finds an error or loses their ID Card.
- Carry the Member ID Card at all times. The Member must present their ID Card whenever they receive Medical Care.

On the reverse side of the ID Card, the Member will find information about medical services, especially useful in Emergencies. There is even a toll-free number for use by Hospitals if the Member has questions about their coverage.

PROGRAM DESIGN FEATURES

This Program is different from traditional health insurance coverage. In addition to covering health care services, access is provided to Member's Medical Care through their Primary Care Physician. **All medical treatment begins with the Member's Primary Care Physician.** (Under certain circumstances, continuing care by a Non-Participating Provider will be treated in the same way as if the Provider were a Participating Provider. See ***Continuity of Care*** appearing later in the Benefit Booklet).

Because the Member's Primary Care Physician is the key to using this Program, it is important to remember the following:
- **The Member should always call their Primary Care Physician first**, before receiving Medical Care, except for conditions requiring Emergency Services. Please schedule routine visits well in advance.

- **When the Member needs Specialist Services** their Primary Care Physician will give the Member an electronic Referral for specific care or will obtain a Preapproval from the Health Benefit Plan when required. A Standing Referral may be available to the Member if they have a life-threatening, degenerative or disabling disease or condition.

  Female Members may visit any participating obstetrical/gynecological Specialist without a Referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care or problem-related obstetrical/gynecological conditions. The Member's Primary Care Physician must obtain a Preapproval for Specialist Services provided by Non-Participating Providers.

- **The Member's Primary Care Physician is required to select a Designated Provider for certain Specialist Services.** Their Primary Care Physician will submit an electronic Referral to his/her Designated Provider for these outpatient Specialist Services:
  - Physical and Occupational Therapy;
  - Diagnostic Services for Members age five and older;
  - Laboratory and Pathology tests

  Designated Providers usually receive a set dollar amount per Member per month (capitation) for their services based on the Primary Care Physicians that have selected them.

  Outpatient services are ***not covered*** when performed by any Provider other than the Member's Primary Care Physician's Designated Provider.

  Before selecting their Primary Care Physician, the Member may want to speak to the Primary Care Physician regarding his/her Designated Providers.

- **The Member's Primary Care Physician provides coverage 24 hours a day, 7 days a week.**

- **All continuing care as a result of Emergency Services** must be provided or Referred by the Member's Primary Care Physician or coordinated through Customer Service.

- **Some services must be authorized by the Member's Primary Care Physician or Referred Specialist or Preapproved by the Health Benefit Plan.** The Member's Primary Care Physician or Referred Specialist works with the Health Benefit Plan's Care Management and Coordination team during the Preapproval process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. To access a complete list of services that require Preapproval, log onto www.ibx.com, or the Member can call Customer Service at the phone number shown on their ID Card to have the list mailed to them. A Member has the right to appeal any decisions through the ***Complaint And Grievance Appeal Process*** described later in this Benefit Booklet. Instructions for the appeal will be described in the denial notifications.

- **All services must be received from Participating Providers** unless Preapproved by the Health Benefit Plan, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area.

- See ***Access To Primary, Specialist, And Hospital Care*** in this section for procedures for obtaining Preapproval for use of a Non-Participating Provider. Use the Provider Directory to

find out more about the individual Providers, including Hospitals and Primary Care Physicians, and Referred Specialists, and their affiliated Hospitals. It includes a foreign language index to help the Member locate a Provider who is fluent in a particular language. The directory also lists whether the Provider is accepting new patients.

- **To change the Member's Primary Care Physician,** call Customer Service at the telephone number shown on their ID Card.

- **Medical Technology Assessment is performed by the Health Benefit Plan.** Technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include and are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Health Benefit Plan uses the technology assessment process to assure that new drugs, procedures or devices are safe and effective before approving them as a Covered Service. When new technology becomes available or at the request of a practitioner or Member, the Health Benefit Plan researches all scientific information available from these expert sources. Following this analysis, the Health Benefit Plan makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service.

- **Prescription Drugs are covered under this Program.** Under this Program, Prescription Drugs, including medications and biologicals, are Covered Services or Supplies when ordered during the Member's Inpatient Hospital stay. In addition, the Member also has Prescription Drug Coverage for Outpatient Prescription Drugs.

  Prescription Drug benefits cover certain over-the-counter drugs including insulin.

  Additionally, Prescription Drug benefits are subject to quantity level limits as conveyed by the Food and Drug Administration ("FDA") or the Health Benefit Plan's Pharmacy and Therapeutics Committee.

  The Health Benefit Plan, for all Prescription Drug benefits, requires Preapproval of a small number of drugs approved by the FDA for use in specific medical conditions. Where Preapproval or quantity limits are imposed, The Member's Physician may request an exception for coverage by providing documentation of Medical Necessity. The Member may obtain information about how to request an exception by calling Customer Service at the phone number on their ID Card.

  The Member, or their Physician acting on their behalf, may appeal any denial of benefits or application of higher cost sharing through the ***Complaint and Grievance Appeal Process*** described later in this Benefit Booklet.

Disease Management And Decision Support

Disease Management and Decision Support programs help Members to be effective partners in their health care by providing information and support to Members with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Members with certain chronic diseases, intervening with specific information or support to follow PCP's and Participating Professional Provider's treatment plan, and measuring clinical and other outcomes. Decision Support involves identifying Members who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their PCP's and

Participating Professional Provider's. Decision Support also includes the availability of general health information, personal health coaching, PCP's and Participating Professional Provider's information, or other programs to assist in health care decisions.

Disease Management interventions are designed to help Members manage their chronic condition in partnership with their PCP's and Participating Professional Provider's. Disease Management programs, when successful, can help such Members avoid long term complications, as well as relapses that would otherwise result in Hospital or Emergency room care. Disease Management programs also include outreach to Members to obtain needed preventive services, or other services recommended for chronic conditions. Information and support may occur in the form of telephonic health coaching, print, audio library or videotape, or Internet formats.

The Health Benefit Plan will utilize medical information such as claims data to operate the Disease Management or Decision Support program, to identify Members with chronic disease for example, to predict which Members would most likely benefit from these services, and to communicate results to Member's treating PCP's and Participating Professional Provider's. The Health Benefit Plan will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Member in Disease Management or Decision Support programs is voluntary. A Member may continue in the Disease Management or Decision Support program until any of the following occurs:

- The Member notifies the Health Benefit Plan that they decline participation; or
- The Health Benefit Plan determines that the program, or aspects of the program, will not continue;
- The Member's Employer decides not to offer the programs.

Discretionary Authority

The Health Benefit Plan retains discretionary authority to interpret this Program and the facts presented to make benefit determinations. Benefits under this Program will be provided only if the Health Benefit Plan determines in its discretion that the Member is entitled to them.

Out-Of-Area Services

Keystone Health Plan East, Inc. ("Keystone") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever the Member obtains healthcare services outside of Keystone's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside Keystone's Service Area, the Member will obtain care from healthcare providers that have a contractual agreement (That is, are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Member may obtain care from non-participating healthcare providers. Keystone's payment practices in both instances are described below.

Keystone covers only limited healthcare services received outside of our Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care, Urgent Care and Follow-up Care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by the Member's Primary Care Physician

("PCP").

BlueCard® Program

- Under the BlueCard® Program, when a Member obtains Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Keystone will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.
- The BlueCard Program enables the Member to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to fill out. The Member will be responsible for the Copayment amount, as stated in the ***Schedule of Covered Services***.
- Non-Participating Healthcare Providers Outside Keystone's Service Area See the ***Preapproval For Non-Participating Providers*** in this section of the Benefit Booklet for information regarding services provided by Non-Participating Providers.

ACCESS TO PRIMARY, SPECIALIST, AND HOSPITAL CARE

Direct Access To Certain Care

A Member does not need a Referral from his/her Primary Care Physician for the following Covered Services:

- Emergency Services;
- Care from a participating obstetrical/gynecological Specialist;
- Mammograms;
- Mental Health Care, Serious Mental Illness Health Care and Alcohol Or Drug Abuse And Dependency;
- Inpatient Hospital Services that require Preapproval. This does not include a maternity Inpatient Admission;
- Dialysis services performed in a Participating Facility Provider or by a Participating Professional Provider;
- Nutrition Counseling for Weight Management; and
- Diabetic Education Program.

How To Obtain A Specialist Referral

The Member should always consult their Primary Care Physician first when they need Medical Care.

If the Member's Primary Care Physician refers them to a Referred Specialist or facility just follow these steps:

- The Member's Primary Care Physician will submit an electronic Referral indicating the services authorized.
- The Member's Referral is valid for 90 days from issue date as long as they are a Member.
- This form is sent electronically to the Referred Specialist or facility before the services are performed. Only services authorized on the Referral form will be covered.
- Any additional Medically Necessary treatment recommended by the Referred Specialist beyond the 90 days from the date of issue of the initial Referral will require another electronic Referral from the Member's Primary Care Physician.
- The Member must be enrolled at the time they receive services from a Referred Specialist or Non-Participating Provider in order for services to be covered.

See the ***Preapproval for Non-Participating Providers*** section of the Benefit Booklet for information regarding services provided by Non-Participating Providers.

How To Obtain A Standing Referral
If the Member has a life-threatening, degenerative or disabling disease or condition, they may receive a Standing Referral to a Participating Professional Provider to treat that disease or condition. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral is granted upon review of a treatment plan by the Health Benefit Plan and in consultation with the Member's Primary Care Physician.

Follow these steps to initiate a Standing Referral request.
- Call Customer Service at the telephone number shown on the Member's ID Card. (Or, the Member may ask their Primary Care Physician to call Provider Services or Care Management and Coordination to obtain a "Standing Referral Request" form.)
- A "Standing Referral Request" form will be mailed or faxed to the requestor.
- The Member must complete a part of the form and their Primary Care Physician will complete the clinical part. The Member's Primary Care Physician will then send the form to Care Management and Coordination.
- Care Management and Coordination will either approve or deny the request for the Standing Referral. The Member, their Primary Care Physician and the Referred Specialist will receive notice of the approval or denial in writing. The notice will include the time period for the Standing Referral.

<u>If the Standing Referral is Approved</u>
If the request for the Standing Referral to a Referred Specialist is approved, the Referred Specialist, the Member, and the Primary Care Physician will be informed in writing by Care Management and Coordination. The Referred Specialist must agree to abide by all the terms and conditions that the Health Benefit Plan has established with regard to Standing Referrals. This includes, but is not limited to, the need for the Referred Specialist to keep the Member's Primary Care Physician informed of their condition. When the Standing Referral expires, the Member or their Primary Care Physician will need to contact Care Management and Coordination and follow the steps outlined above to see if another Standing Referral will be approved.

<u>If the Standing Referral is Denied</u>
If the request for a Standing Referral is denied, the Member and their Primary Care Physician will be informed in writing. The Member will be given information on how to file a formal Complaint, if they so desire.

Designating A Referred Specialist As A Member's Primary Care Physician
If the Member has a life-threatening, degenerative or disabling disease or condition, they may have a Referred Specialist named to provide and coordinate both their primary and specialty care. The Referred Specialist will be a Physician with clinical expertise in treating their disease or condition. It is required that the Referred Specialist agrees to meet the Program’s requirements to function as a Primary Care Physician.

Follow these steps to initiate a request for a Member's Referred Specialist to be their Primary Care Physician.

- Call Customer Service at the telephone number shown on the Member's ID Card. (Or, the Member may ask their Primary Care Physician to call Provider Services or Care Management and Coordination to initiate the request.).
- A "Request for Specialist to Coordinate All Care" form will be mailed or faxed to the requestor.
- The Member must complete a part of the form and their Primary Care Physician will complete the clinical part. The Member's Primary Care Physician will then send the form to Care Management and Coordination.
- The Medical Director will speak directly with the Member's Primary Care Physician and the selected Referred Specialist to apprise all parties of the primary services that the Referred Specialist must be able to provide in order to be designated as a Member's Primary Care Physician. If Care Management and Coordination approves the request, it will be sent to the Provider Service area. That area will confirm that the Referred Specialist meets the same credentialing standards that apply to Primary Care Physicians. (At the same time, the Member will be given a Standing Referral to see the Referred Specialist.).

If the Referred Specialist as Primary Care Physician Request is Approved

If the request for the Referred Specialist to be the Member's Primary Care Physician is approved, the Referred Specialist, the Member's Primary Care Physician and the Member will be informed in writing by Care Management and Coordination.

If the Referred Specialist as Primary Care Physician Request is Denied

If the request to have a Referred Specialist designated to provide and coordinate the Member's primary and specialty care is denied, the Member and their Primary Care Physician will be informed in writing. The Member will be given information on how to file a formal Complaint, if they so desire.

Changing A Member's Primary Care Physician

The Member may change their Primary Care Physician up to two times within each Benefit Period. To do so, simply call Customer Service at the telephone number shown on the Member's ID Card. The change will be effective on the first of the month following the Member's phone call. The Member must remember to have their medical records transferred to their new Primary Care Physician.

If the participating status of the Member's Primary Care Physician changes, they will be notified in order to select another Primary Care Physician.

Changing A Member's Referred Specialist

The Member may change the Referred Specialist to whom they have been referred by their Primary Care Physician or for whom the Member has a Standing Referral. To do so, the Member asks their Primary Care Physician to recommend another Referred Specialist before services are performed. Or, the Member may call Customer Service at the telephone number shown on their ID Card. Remember, only services authorized on the Referral form will be covered.

If the participating status of a Referred Specialist the Member regularly visits changes, they will be notified to select another Referred Specialist.

Continuity Of Care
The Member has the option, if their Physician agrees to be bound by certain terms and conditions as required by the Health Benefit Plan, of continuing an ongoing course of treatment with that Physician. This continuation of care shall be offered through the current period of active treatment for an acute condition or through the acute phase of a chronic condition or for up to 90 calendar days from the notice that the status of the Member's Physician has changed or the Member's Effective Date of Coverage when:

- The Member's Physician is no longer a Participating Provider because the Health Benefit Plan terminates its contract with that Physician, for reasons other than cause; or
- The Member first enrolls in this Program and is in an ongoing course of treatment with a Non-Participating Provider.

If the Member is in their second or third trimester of pregnancy at the time of their enrollment or termination of a Participating Provider's contract, the continuity of care with that Physician will extend through post-partum care related to the delivery.

The Member should follow these steps to initiate their continuity of care:

- Call Customer Service at the number on the Member's ID Card and ask for a "Request for Continuation of Treatment" form.
- The "Request for Continuation of Treatment" form will be mailed or faxed to the Member.
- The Member must complete the form and send it to Care Management and Coordination at the address that appears on the form.

If the Member's Physician agrees to continue to provide their ongoing care, the Physician must also agree to be bound by the same terms and conditions as apply to Participating Providers.

The Member will be notified when the participating status of their Primary Care Physician changes so that they can select another Primary Care Physician.

Preapproval For Non-Participating Providers
The Health Benefit Plan may approve payment for Covered Services provided by a Non-Participating Provider if the Member has:

- First sought and received care from a Participating Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the Non-Participating Provider that the Member has requested. (The Member's Primary Care Physician is required to obtain Preapproval from the Health Benefit Plan for services provided by a Non-Participating Provider.);
- Been advised by the Participating Provider that there are no Participating Providers that can provide the requested Covered Services; and
- Obtained authorization from the Health Benefit Plan prior to receiving care. The Health Benefit Plan reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.

If the Health Benefit Plan approves the use of a Non-Participating Provider, the Member will not be responsible for the difference between the Provider's billed charges and the Health Benefit Plan's payment to the Provider but the Member will be responsible for applicable cost-sharing amounts. If the Member receives any bills from the Provider, they need to contact Customer Service at the telephone number on their ID card. When the Member notifies the Health Benefit Plan about these bills, the Health Benefit Plan will resolve the balance billing.

Hospital Admissions

- If the Member needs hospitalization or outpatient Surgery, the Member's Primary Care Physician or Referred Specialist will arrange admission to the Hospital or outpatient surgical facility on their behalf.
- The Member's Primary Care Physician or Referred Specialist will coordinate the Preapproval for their outpatient Surgery or Inpatient admission with the Health Benefit Plan, and the Health Benefit Plan will assign a Preapproval number. Preapproval is not required for a maternity Inpatient Admission.
- The Member does not need to receive an electronic Referral from their Primary Care Physician for Inpatient Hospital Services that require Preapproval.

Upon receipt of information from the Member's Primary Care Physician or Referred Specialist, Care Management and Coordination will evaluate the request for hospitalization or outpatient Surgery based on clinical criteria guidelines. Should the request be denied after review by a Health Benefit Plan Medical Director, the Member, their Primary Care Physician or their Referred Specialist has a right to appeal this decision through the Grievance appeal process.

During an Inpatient hospitalization, Care Management and Coordination is monitoring the Member's Hospital stay to assure that a plan for their discharge is in place. This is to make sure that the Member has a smooth transition from the Hospital to home, or to another setting such as a Skilled Nursing or Rehabilitation Facility. A Health Benefit Plan Case Manager will work closely with the Member's Primary Care Physician or Referred Specialist to help with their discharge and if necessary, arrange for other medical services.

Should the Member's Primary Care Physician or Referred Specialist agree with the Health Benefit Plan that Inpatient hospitalization services are no longer required, the Member will be notified in writing of this decision. Should the Member decide to remain hospitalized after this notification, the Hospital has the right to bill the Member after the date of the notification. The Member may appeal this decision through the Grievance appeal process.

Recommended Plan Of Treatment

The Member agrees, when enrolling in this Program, to receive care according to the recommendations of their Primary Care Physician or Referred Specialist. The Member has the right to give their informed consent before the start of any procedure or treatment. The Member also has the right to refuse any drugs, treatment or other procedure offered to them by providers in the Health Benefit Plan's network, and to be informed by their Physician of the medical consequences of their refusal of any drugs, treatment, or procedure.

The Health Benefit Plan and the Member's Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if the Member still refuses the recommended Plan of Treatment, the Health Benefit Plan will not be responsible for the costs of further treatment for that condition and the Member will be so notified. The Member may use the Grievance appeal process to have their case reviewed, if they so desire.

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of Providers and services, to the procedures required for obtaining benefits for Covered Services under this Program described in this Benefit Booklet (For example, obtaining Referrals, use of Participating Providers), or to the administration of this Program by the Health Benefit Plan, the Health Benefit Plan may, on a selective basis, waive certain procedural requirements of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such

period of time as is required by the Special Circumstances as defined below.

The Health Benefit Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Health Benefit Plan shall provide access to Covered Services in so far as practical, and according to its best judgment. Neither the Health Benefit Plan nor Providers in the Health Benefit Plan's network shall incur liability or obligation for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances, as recognized in the community and by the Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:

- A major disaster;
- An epidemic;
- A pandemic;
- Riot;
- Civil insurrection; or
- The complete or partial destruction of facilities.

Member Liability
Except when certain cost sharing is specified in this Benefit Booklet or on the ***Schedule of Covered Services***, the Member is not liable for any charges for Covered Services when these services have been provided or Referred by their Primary Care Physician and they are eligible for such benefits on the date of service.

Right To Recover Payments Made In Error
If the Health Benefit Plan should provide coverage for any contractually excluded services through inadvertence or error, the Health Benefit Plan maintains the right to seek recovery of such payment from the Provider or Member to whom such payment was made.

INFORMATION ABOUT PROVIDER REIMBURSEMENT
The Health Benefit Plan reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for our Members. Set forth below is a general description of the Health Benefit Plan reimbursement programs, by type of participating health care provider. These programs vary by state.

Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If after reading this material the Member has any questions about how their health care provider is compensated, please speak with them directly or contact Customer Service.

Professional Providers
Primary Care Physicians: Most Primary Care Physicians (PCPs) are paid in advance for their services, receiving a set dollar amount per Member, per month for each Member selecting that PCP. This is called a capitation payment and it covers most of the care delivered by the PCP. Covered Services not included under capitation are paid fee-for-service according to the Health Benefit Plan fee schedule. Many Pennsylvania based PCPs are also eligible to receive additional payments for meeting certain medical quality, patient service and other performance standards. In Pennsylvania, the PCP Quality Incentive Payment System (QIPS) includes incentives for practices that have extended hours and submit encounter and referral data electronically, as well as an incentive that is based on the extent to which a PCP prescribes generic drugs (when available) relative to similar PCPs. In addition, the Practice Quality Assessment Score focuses on preventive care and other established clinical interventions.

Referred Specialists: Most Referred Specialists are paid on a fee-for-service basis, meaning that payment is made according to the Health Benefit Plan's fee schedule for the specific medical services that the Referred Specialist performs. Obstetricians are paid global fees that cover most of their professional services for prenatal care and for delivery.

Designated Providers: For a few specialty services, PCPs are required to select a Designated Provider to which they refer all of the Health Benefit Plan patients for those services. The Specialist services for which PCPs must select a Designated Provider vary by state and could include, but are not limited to, radiology and Physical Therapy. Designated Providers usually are paid a set dollar amount per Member per month (capitation) for their services based on the PCPs that have selected them. Before selecting a PCP, Members may want to speak to the PCP regarding the Designated Provider that PCP has chosen.

Hospital-Based Provider: When the Member receives Covered Services from a Hospital-Based Provider while they are an Inpatient at a Participating Hospital or other Participating Facility Provider and are being treated by a Participating Professional Provider, the Member will receive benefits for the Covered Services provided by the Non-Participating Hospital-Based Provider. A Hospital-Based Provider can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the Health Benefit Plan's payment to the Hospital-Based Providers (That is, "balance billing"). If the Member receives any bills from the Provider, the Member needs to contact Customer Services at the telephone number on the ID card. When the Member notifies the Health Benefit Plan about these bills, the Health Benefit Plan will resolve the balance billing.

Institutional Providers

Hospitals: For most inpatient medical and surgical Covered Services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, (For example, transplants).

For most outpatient and Emergency Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient Covered Services (For example, lab and radiology) that includes both the facility and Physician payment. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various Covered Services.

Some Hospitals participate in a quality incentive program. The program provides increased reimbursement to these Hospitals when they meet specific quality and other criteria, including "Patient Safety Measures." Such patient safety measures are consistent with recommendations by The Leap Frog Group, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ) and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic submissions. This incentive program is expected to evolve over time.

Skilled Nursing Homes, Rehabilitation Hospitals, and other care facilities: Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Member is in the facility. These amounts may vary according to the intensity of services provided.

Ambulatory Surgical Centers (ASCs)
Most ASCs are paid specific rates based on the type of service performed. For a few Covered Services, some ASCs are paid based on a percentage of billed charges

Physician Group Practices and Physician Associations
Certain Physician group practices and independent Physician associations (IPAs) employ or contract with individual Physicians to provide medical Covered Services. These groups are paid as outlined above. These groups may pay their affiliated Physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers
Some ancillary service providers, such as Durable Medical Equipment and Home Health Care Providers, are paid fee-for-service payments according to the Health Benefit Plan fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory, dental or vision Covered Services, are paid a set dollar amount per Member per month (capitation). Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Mental Health/Alcohol Or Drug Abuse And Dependency
A Mental Health/Alcohol Or Drug Abuse And Dependency ("behavioral health") management company administers most of the behavioral health benefits, provides a network of Participating Behavior Specialists and processes the related claims. The behavioral health management company is paid a set dollar amount per Member per month (capitation) for each Member and is responsible for paying its contracted providers on a fee-for-service basis. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters.

A subsidiary of Independence Blue Cross has a less than one percent ownership interest in this behavioral health management company.

Pharmacy
A pharmacy benefits management company (PBM), which is affiliated with the Health Benefit Plan, administers the Prescription Drug benefits, and is responsible for providing a network of Participating Pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The Health Benefit Plan anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of Prescription Drug benefits. Under most benefit plans, Covered Drugs Or Supplies are subject to the Member's cost-sharing.

UTILIZATION REVIEW PROCESS AND CRITERIA

Utilization Review Process

Two conditions of this Program are that in order for a health care service to be covered or payable, the service must be:

- Eligible for coverage under this Program; and,
- Medically Necessary.

To assist the Health Benefit Plan in making coverage determinations for certain requested health care services, the Health Benefit Plan uses established Health Benefit Plan medical policies and medical guidelines based on clinically credible evidence to determine the Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Member's benefit plan is called utilization review.

It is not practical to verify Medical Necessity on all procedures on all occasions, therefore certain procedures may be determined by the Health Benefit Plan to be Medically Necessary and automatically approved based on the accepted Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which have been approved by the Health Benefit Plan based on the procedure meeting Emergency criteria and the severity of diagnosis reported (For example, rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed (pre-service review) it is called Precertification (applicable when the Member's benefit plan provides benefits for services performed without the required Referral or by Non-Participating Providers (That is, point-of-service coverage) or Preapproval. Reviews occurring during a Hospital stay are called concurrent reviews. Those reviews occurring after services have been performed (post-service reviews) are called retrospective reviews. The Health Benefit Plan follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Necessity review, nurses perform the initial case review and evaluation for plan coverage approval using the Health Benefit Plan's medical policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director may deny coverage for a procedure based on Medical Necessity. The evidence-based clinical protocols evaluate the Medical Necessity of specific procedures and the majority is computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable benefit plan policies and procedures, taking into consideration the individual Member's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a Medical Director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Necessity a letter is sent to the requesting Provider and Member in accordance with applicable law.

The Health Benefit Plan's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing Physicians with direct access to plan Medical Directors to discuss coverage of a case. The nurses, Medical Directors, other Professional Providers, and independent medical consultants who perform utilization review services are not compensated or given incentives based on their coverage review decisions. Medical Directors and nurses are salaried, and contracted external Physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Health Benefit Plan does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

Precertification or Preapproval
When required and applicable, Precertification or Preapproval evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Member's benefit plan. Examples of these services include certain planned or elective Inpatient Admissions and selected outpatient procedures according to the Member's benefit plan. Where required by the Member's benefit plan, Preapproval is initiated by the Provider and Precertification is initiated by the Member.

Where Precertification or Preapproval is required, coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied when Precertification is required for a procedure but is not obtained. If the Primary Care Physician or Referred Specialist fails to obtain Preapproval when required, and provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment.

While the majority of services requiring Precertification or Preapproval are reviewed for medical appropriateness of the requested procedure setting (For example, inpatient, Short Procedure Unit, or outpatient setting), other elements of the Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing Provider. Precertification or Preapproval is not required for Emergency services and is not performed where an agreement with the Participating Provider does not require such review.

The following are general examples of current Precertification or Preapproval requirements under benefit plans; however these requirements vary by benefit plan and state and are subject to change

- Hysterectomy;
- Nasal Surgery procedures;
- Bariatric Surgery; and
- Potentially cosmetic or Experimental/Investigative Services.

Concurrent Review
Concurrent review may be performed while services are being performed. This may occur during an Inpatient Admission and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. When performed, the review assesses the level of care provided to the Member and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all inpatient stays are reviewed concurrently. Concurrent review is generally not performed where an inpatient facility is paid

based on a per case or diagnosis-related basis, or where an agreement with the facility does not require such review.

Retrospective Review
Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Health Benefit Plan not being notified of a Member's Inpatient Admission until after discharge or where medical charts are unavailable at the time of a required concurrent review. Certain services are only reviewed on a retrospective basis.

Prenotification
In addition to the standard utilization reviews outlined above, the Health Benefit Plan also may determine coverage of certain procedures and other benefits available to Members through Prenotification, as required by the Members' benefit plan, and discharge planning. Prenotification is advance notification to the Health Benefit Plan of an Inpatient Admission or Outpatient service where no Medical Necessity review (Precertification or Preapproval) is required, such as maternity admissions/deliveries. Prenotification is primarily used to identify Members for concurrent review needs, to ascertain discharge planning needs proactively, and to identify who may benefit from Case Management programs.

Discharge Planning
Discharge planning is performed during an Inpatient Admission and is used to identify and coordinate a Member's needs and benefit plan coverage following the Inpatient Admission, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves the Health Benefit Plan's authorization of post-Hospital Covered Services and identifying and referring Members to Disease Management or Case Management benefits.

Selective Medical Review
In addition to the foregoing requirements, the Health Benefit Plan reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("selective medical review") that are otherwise not subject to review as described above. In addition, the Health Benefit Plan reserves the right to waive medical review for certain Covered Services for certain Providers, if the Health Benefit Plan determines that those Providers have an established record of meeting the utilization and/or quality management standards for those Covered Services. Regardless of the outcome of the Health Benefit Plan's selective medical review, there are no coverage penalties applied to the Member.

CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medical Necessity coverage decisions:

Clinical Decision Support Criteria
Clinical decision support criteria are an externally validated and computer-based system used to assist the Health Benefit Plan in determining Medical Necessity. These evidence-based, clinical Decision Support criteria are nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist the Health Benefit Plan's clinical staff in evaluating the Medical Necessity and appropriateness of coverage based on a Member's specific clinical needs. Clinical decision support criteria help promote consistency in the Health Benefit Plan's plan determinations for similar medical issues and

requests, and reduce practice variation among the Health Benefit Plan's clinical staff to minimize subjective decision-making.

Clinical decision support criteria may be applied for Covered Services including, but not limited to the following:

- Some elective surgeries—settings for Inpatient and Outpatient procedures (For example, hysterectomy and sinus surgery);
- Inpatient Hospital Services;
- Inpatient rehabilitation care;
- Home Health Care;
- Durable Medical Equipment (DME); and
- Skilled Nursing Facility Services.

Centers for Medicare and Medicaid Services (CMS) Guidelines
These are a set of guidelines adopted and published by CMS for coverage of services by Medicare and Medicaid for persons who are eligible and have health coverage through Medicare or Medicaid.

The Health Benefit Plan's Medical Policies
These are the Health Benefit Plan's internally developed set of policies which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

The Health Benefit Plan's medical polices may be applied for Covered Services including, but not limited to the following:

- Ambulance;
- Infusion;
- Speech Therapy;
- Occupational Therapy;
- Durable Medical Equipment (DME); and
- Review of potential cosmetic procedures.

The Health Benefit Plan's Internally Developed Guidelines
These are a set of guidelines developed specifically by the Health Benefit Plan, as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting the Health Benefit Plan's medical policies for benefit plan coverage.

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

The Health Benefit Plan delegates its utilization review process to its affiliate, Independence Healthcare Management, a state- licensed utilization review entity. In certain instances, the Health Benefit Plan has delegated certain utilization review activities, which may include Preapproval, Precertification, concurrent review, and Case Management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, neonates/premature infants) or a type of benefit or service (such as behavioral health or radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Health Benefit Plan's approval.

Utilization Review and Criteria for Behavioral Health Services
Utilization Review activities for behavioral health services (mental health and Alcohol or Drug Abuse and Dependency services) have been delegated by the Health Benefit Plan to its contracted behavioral health management company which administers the behavioral health benefits for the majority of the Health Benefit Plan's Member's.

COORDINATION OF BENEFITS

If a Member or any of their Dependents have other group health insurance coverage which provides benefits for Hospital, medical, or other health expenses, the Member's benefit payments may be subject to Coordination of Benefits (COB). COB refers to the administration of health benefit coverage when a person is covered by more than one group plan. COB provisions:

- Determine which health plan will be the primary payor and which will be the secondary payor;
- Regulate benefit payments so that total payments by all insurers do not exceed total charges for Covered Services;
- Apply to all Member benefits, however, the Health Benefit Plan will provide access to Covered Services first and apply the applicable COB rules later;
- Allow the Health Benefit Plan to recover any expenses paid in excess of its obligation as a non-primary payor; and
- Apply to services for the treatment of injury resulting from the maintenance or use of a motor vehicle.

Coordination of Benefit provisions do not apply to Prescription Drug or Vision Care coverage.

Coordination of Benefits Administration

Determination will be made as to whether the Member is also entitled to receive benefits under any other group health care insurance plan or under any governmental program for which any periodic payment is made by or for the Member, with the exception of student accident plans, group hospital indemnity plans paying one hundred dollars ($100) per day or less and, if provided under the Member's Program, coverage for Prescription Drug or vision expenses. If so, the Health Benefit Plan shall determine whether the other insurer or government plan has primary responsibility for payment. In these cases, the payment under this Program may be reduced or eliminated. The Health Benefit Plan will provide access to Covered Services first and determine liability later.

If it is determined that this Program is the secondary plan, the Health Benefit Plan has the right to recover the expense already paid in excess of this Program's liability as the secondary plan. In such cases, only care provided or Referred by the Member's Primary Care Physician will be covered by this Program as secondary. The Member is required to furnish information and to take such other action as is necessary to assure the rights of the Health Benefit Plan. In determining whether this Program or another group health plan has primary liability the following will apply.

- If another plan under which an individual has coverage with does not have a COB provision, that plan will be primary and this Program will be secondary. In order for services to be covered by this Program as secondary, the Member's care must be provided or Referred by their Primary Care Physician.
- If the other plan does include a Coordination of Benefits or non-duplication provision:
  - The plan which covers an individual as a Subscriber (meaning not a dependent) will be primary. The plan which covers the individual as a dependent will be secondary;
  - If there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan;
  - Where both plans cover a child as a dependent, the plan of the parent whose date of birth (excluding year) occurs earlier in the calendar year will be primary (the Birthday

Rule). If both parents have the same birthday, the plan covering the parent longer will be primary. If the other plan does not include this provision, the provisions of that plan will determine the order of benefits.

  - If parents are separated or divorced, and no court decree applies, the benefits for the child will be determined as follows:
    - The plan of the parent with custody of the child will be primary;
    - The plan of the spouse of the parent with custody of the child will be secondary;
    - The plan of the parent not having custody of the child will be third;
    - In cases of joint custody, benefits will be determined by the Birthday Rule.
  - Where there is a court decree which establishes financial responsibility for the health care expenses of the child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan.
  - In cases of joint custody, benefits will be determined by the Birthday Rule as described in the second bulleted item above regarding the "Coordination of Benefits or non-duplication provision".
- The benefits of a plan covering the patient as a laid-off or retired employee or as the Dependent of a laid off or retired employee shall be determined after the benefits of any other plan covering such person as an employee or dependent of such person. If the other plan does not have the rule regarding laid-off or retired employees, and if, as a result, the plans do not agree on the order of benefits, the rule will be ignored.
- Where the determination cannot be made in accordance with the preceding paragraphs, the plan which has covered the patient for the longer period of time will be the primary plan.
- Expenses for the treatment of injury arising out of the maintenance or use of a motor vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:
  - Under a plan or policy of motor vehicle insurance, provided that non-duplication as contained herein is not prohibited by law; or
  - Through a program or other arrangement of qualified or certified self-insurance.
- The Health Benefit Plan may release to or obtain from any person or organization any information about coverage, expenses and benefits, which may be necessary to determine whether this Program has the primary responsibility of payment. For the purpose of COB, if the Member receives services or supplies available under this Benefit Booklet but such is not provided by nor Referred by the Member's Primary Care Physician payment will not be made by this Program except as provided under this Benefit Booklet.
- Services provided under any governmental program for which any periodic payment is made by or for the Subscriber shall always be the primary plan, except where prohibited by law.

This provision does not apply to an individual health care plan issued to or in the name of the Member.

SUBROGATION

In the event that legal grounds for the recovery of health care costs exist (such as when an illness or injury is caused by the negligence or wrong doing of another party), the Health Benefit Plan has the right to seek recovery of such costs on behalf of the Group, unless prohibited by statute or regulation. When requested, the Member must cooperate with the Health Benefit Plan to provide information, sign necessary documents, and take any action necessary to protect and assure the subrogation rights of the Health Benefit Plan.

CLAIM PROCEDURES

Most claims are filed by Providers in the Health Benefit Plan's network. The following applies if

the Member must submit a claim.

Notice of Claims
The Health Benefit Plan will not be liable for any claims under this Program unless proper notice is furnished to the Health Benefit Plan that Covered Services in this Program have been rendered to a Member.

Written notice of a claim must be given to the Health Benefit Plan within 20 days, or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Health Benefit Plan that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a claim to the Health Benefit Plan.

The Member can give notice to the Health Benefit Plan by calling Customer Service. The telephone number and address of Customer Service can be found on the Member's ID Card. A charge shall be considered Incurred on the date a Member receives the Covered Service for which the charge is made.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to the Health Benefit Plan. Written proof of loss must be provided to the Health Benefit Plan within 90 days after the charge for Covered Services is Incurred. Proof of loss must include all data necessary for the Health Benefit Plan to determine benefits. Failure to submit a proof of loss to the Health Benefit Plan within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Health Benefit Plan be required to accept a proof of loss later than 12 months after the charge for Covered Services is Incurred.

Claim Forms
If a Member (or if deceased, by his/her personal representative) is required to submit a proof of loss for benefits under this Program, it must be submitted to the Health Benefit Plan on the appropriate claim form. The Health Benefit Plan, upon receipt of a notice of claim will, within 15 days following the date notice of claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for Covered Services as described below. Itemized bills may be submitted to the Health Benefit Plan at the address appearing on the Member’s ID Card. Itemized bills cannot be returned.

Submission of Claims Forms
For Member-submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to the Health Benefit Plan at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Program.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

- Person or organization providing the service or supply;
- Type of service or supply;
- Date of service or supply;
- Amount charged; and
- Name of patient.

A request for payment of a claim will not be reviewed and no payment will be made unless all the information and evidence of payment required on the claim form has been submitted in the manner described above. The Health Benefit Plan reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Timely Payment of Claims
Claims payment for benefits payable under this Program will be processed immediately upon receipt of proper proof of loss.

COMPLAINT AND GRIEVANCE APPEAL PROCESS

GENERAL INFORMATION ABOUT THE APPEAL PROCESSES

The Health Benefit Plan maintains a Complaint appeal process and a Grievance appeal process for its Members. Each of these appeal processes provides formal review for a Member's dissatisfaction with a denial of coverage or other issues related to his/her health plan underwritten by the Health Benefit Plan.

The Complaint appeal process and the Grievance appeal process focus on different issues and have other differences. **Please refer to the separate sections below entitled Member Complaint Appeal Process and Member Grievance Appeal Process for specific information on each process**.

However, the Complaint appeal process and Grievance appeal process also have some common features. To understand how to pursue a Member appeal, the Member should also review the background information outlined here that applies to both the Complaint appeal process and the Grievance appeal process.

- **Authorizing Someone To Represent the Member.** At any time, the Member may choose a third party to be their representative in their Member appeal such as a Provider, lawyer, relative, friend, another individual, or a person who is part of an organization. The law states that the Member's written authorization or consent is required in order for this third party—called an "Appeal Representative" or "Authorized Representative"—to pursue an appeal on the Member's behalf. An Appeal Representative may make all decisions regarding the Member's appeal, provide and obtain correspondence, and authorize the release of medical records and any other information related to their appeal. In addition, if the Member chooses to authorize an Appeal Representative, the Member has the right to limit their authority to release and receive the Member's medical records or other appeal information in any other way the Member identifies.

  In order to authorize someone to be the Member's Appeal Representative, the Member must complete valid authorization forms. The required forms are sent to adult Members or to the

parents, guardians or other legal representatives of minor or incompetent Members who appeal and indicate that they want an Appeal Representative. Authorization forms can be obtained by calling or writing to the address listed below:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

Except in the case of an Expedited appeal, the Health Benefit Plan must receive completed, valid authorization forms before the Member's appeal can be processed. (For information on Expedited appeals, see the definition below and the references in the Member Complaint Appeal Process and Member Grievance Appeal Process sections below.) The Member has the right to withdraw or rescind authorization of an Appeal Representative at any time during the process.

If the Member's Provider files an appeal on the Member's behalf, the Health Benefit Plan will verify that the Provider is acting as the Member's Appeal Representative with their permission by obtaining valid authorization forms. A Member who authorizes the filing of an appeal by a Provider cannot file a separate appeal.

Information for the Appeal Review:

- How to File and Get Assistance **-** Appeals may be submitted by the Member or their Appeal Representative with the Member's authorization by following the steps outlined below in the descriptions of the Member Complaint Appeal Process and Member Grievance Appeal Process. At any time during these appeal processes, the Member may request the help of a Health Benefit Plan employee in preparing or presenting their appeal; this assistance will be available at no charge. Please note that the Health Benefit Plan employee designated to assist the Member will not have participated in the previous decision to deny coverage for the issue in dispute and will not be a subordinate of the original reviewer.
- Full and Fair Review - The Member or designee is entitled to a full and fair review. Specifically, at all appeal levels the designee may submit additional information pertaining to the case, to the Health Benefit Plan. The Member or designee may specify the remedy or corrective action being sought. At the Member's request, the Health Benefit Plan will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Health Benefit Plan will automatically provide the Member or designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or designee at no charge.
- Advanced Notice - The Health Benefit Plan will not terminate or reduce an-ongoing course of treatment without providing the Member or designee with advance notice and the opportunity for advanced review.
- Urgent Care - An urgent expedited appeal is any appeal for Medical Care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Members with

Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

- Changes in Member Appeals Processes - Please note that the Members Appeal processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Members Appeals processes, or to reflect other decisions regarding the administration of Members Appeal processes for this Program.
- Appeal Decision Letters - If the Member's appeal request is not granted in full, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Member may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Member or designee may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.
- Appeal Classifications**.** The two classifications of appeals - Complaints and Grievances - established by Pennsylvania state laws and regulations are described in detail in separate sections below. A Grievance appeal may be filed when the denial of a Covered Service is based primarily on Medical Necessity. A Complaint appeal may be filed to challenge a denial based on a Contract Limitation or to complain about other aspects of health plan policies or operations.

The Member may question the classification of their appeal as a Complaint or Grievance by contacting the Health Benefit Plan's Member Appeals Department or their assigned appeals specialist at the address and telephone number shown above or by contacting the Pennsylvania Department of Health or the Pennsylvania Insurance Department at:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health and Welfare Bldg.
625 Forster Street
Harrisburg, PA. 17120-0701
Toll Free: 1-888-466-2787
1-717-787-5193
Fax: 1-717-705-0947

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA. 17120
1-877-881-6388
Fax: 1-717-787-8585

Appeals are also subject to the following classifications that affect the time available to conduct the appeal review:

A **Pre-service** appeal is any appeal for benefits with a coverage requirement that Preapproval or Precertification by the Health Benefit Plan must be obtained before Medical Care and services are received. A maximum of **15 days** is available for each of the two levels of internal review available for a standard Pre-service appeal.

A **Post-service** appeal includes any appeal for benefits for Medical Care or services that a Member has already received. A maximum of **30 days** is available for each of the two levels of internal review available for a standard Post-service appeal.

A maximum of **48 hours** is available for internal review of an Urgent/Expedited appeal.

COMPLAINT APPEAL PROCESS

Informal Member Complaint Process

The Health Benefit Plan will make every attempt to answer any questions or resolve any concerns the Member has related to benefits or services.

If the Member has a concern, they should call Customer Service at the telephone number listed on their ID card, or write to

Manager of Customer Service
Keystone Health Plan East, Inc
P.O. Box 8339
Philadelphia, PA 19101-8339

Most Member concerns are resolved informally at this stage. If the Health Benefit Plan cannot immediately resolve the Member's concern, we will acknowledge it in writing within **five business days** of receiving it. If the Member is not satisfied with the response to their concern from the Health Benefit Plan, the Member has the right to file a formal Complaint appeal within **180 calendar days**, through the **Formal Member Complaint Appeal Process** described below.

Formal Member Complaint Appeal Process

The Member may file a formal Complaint appeal regarding an unresolved dispute or objection regarding coverage, including this Program's exclusions and non-Covered Services, coverage Limitations, Participating or Non-Participating Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions), or the operations or management policies of the Health Benefit Plan. The Complaint process consists of two internal levels of review by the Health Benefit Plan, and one external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department. There is also an internal Expedited Complaint process in the event the Member's condition involves an urgent issue.

Internal Complaint Appeals

Internal First Level Standard Complaint Appeals

The Member may file a formal, first level standard Complaint appeal within 180 calendar days from either their receipt of the original notice of denial from the Health Benefit Plan or completion of the Informal Member Complaint Appeal Process described above. To file a first level standard Complaint appeal, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

The Health Benefit Plan will acknowledge receipt of the Member's Complaint appeal in writing within five business days of receipt of the request.

The First Level Complaint Committee will complete its review of the Member's standard

Complaint appeal within:
- **15 calendar days** from receipt of a Pre-service appeal; and
- **30 calendar days** from receipt of a Post-service appeal.

The First Level Complaint Committee is composed of one Health Benefit Plan employee who has had no previous involvement with the Member's case and who is not subordinate to the person who made the original determination. The Member will be sent their decision in writing within the timeframes noted above. If the Member's Complaint appeal is denied, the decision letter states:
- The specific reason for the decision;
- This Program's provision on which the decision is made and instructions on how to access the provision; and,
- How to appeal to the next level if the Member is not satisfied with the decision.

Internal Second Level Standard Complaint Appeals
If the Member is not satisfied with the decision from their first level standard Complaint, they may file a second level standard Complaint to the Second Level Complaint Committee within 60 calendar days of their receipt of the First Level Complaint Committee's decision from the Health Benefit Plan. To file a second level standard Complaint, call, write or fax the Member Appeals Department at the address and telephone numbers listed above.

The Member has the right to present their Complaint appeal to the Committee in person or by way of a conference call. The Member's appeal can also be presented by their Provider or another Appeal Representative if their authorization is obtained. (See General Information about Member Appeal Processes above for information about authorizations.) The Health Benefit Plan will attempt to contact the Member to schedule the Second Level Complaint Committee meeting for their standard Complaint appeal.

Upon receipt of the Member's appeal, the Member will be notified in writing when possible 15 calendar days in advance of a date and time scheduled for the Second Level Complaint Committee's meeting. The Member may request a change in the meeting schedule. We will do our best to accommodate their request while remaining within the established timeframes. If the Member does not participate in the meeting, the Second Level Complaint Committee will review their Complaint appeal and make its decision based on all available information.

The Second Level Complaint Committee meets and renders a decision on the Member's standard Complaint appeal within:
- **15 calendar days** from receipt of a Pre-service appeal; and
- **30 calendar days** from receipt of a Post-service appeal.

The Second Level Complaint Committee is composed of at least three persons who have had no previous involvement with the Member's case and who are not subordinates of the person who made the original determination. The Second Level Complaint Committee members will include the Health Benefit Plan's staff, with one third of the Committee being Members or other persons who are not employed by the Health Benefit Plan. The Member may submit supporting materials both before and at the appeal meeting. Additionally, the Member has the right to review all information considered by the Committee that is not confidential, proprietary or privileged.

The Second Level Complaint Committee meeting is a forum where Members have an opportunity to present their issues in an informal setting that is not open to the public. Two other

persons may accompany the Member unless they receive prior approval from the Health Benefit Plan for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as the Member's Appeal Representative or to provide general, personal assistance. Members, Appeal Representatives and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Member will be sent the decision letter of the Second Level Complaint Committee on their standard Complaint appeal within the timeframes noted above. The decision is final unless the Member chooses to appeal to the Pennsylvania Insurance Department or Department of Health as described in the decision letter. (See also **External Complaint Appeals** below.)

Internal Expedited Complaint Appeals
If the Member's case involves an urgent issue, then the Member or their Physician may ask to have their case reviewed in a faster manner, as an internal Expedited Complaint. There is only one internal level of appeal review for an Expedited Complaint appeal.

Members with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an internal Expedited Complaint Appeal, call Customer Service at the toll free telephone number listed on the Member's ID card or call or fax the Member Appeals Department at the address or telephone numbers listed above. The Health Benefit Plan will promptly inform the Member whether their appeal request qualifies for Expedited review or instead will be processed as a standard Complaint appeal. The Expedited Complaint Committee has the same composition as a Second Level Complaint Committee for a standard Complaint appeal—three persons who have had no previous involvement with the Member's case and who are not subordinates of the person who made the original determination. The Committee members include the Health Benefit Plan's staff, with one third of the Committee being members or other persons who are not employed by the Health Benefit Plan.

The Member has the right to present their Expedited Complaint to the Committee in person or by way of a conference call. The Member appeal can also be presented by their Provider or another Appeal Representative if the Member's authorization is obtained. (See **General Information About Member Appeal Processes** above for information about authorizations.) If the Member does not participate in the meeting, the Expedited Complaint Committee will review their Complaint appeal and make its decision based on all available information.

The Expedited Complaint Committee meeting is a forum where Members have an opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany the Member unless the Member receives prior approval from the Health Benefit Plan for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as the Member's Appeal Representative or to provide general, personal assistance. Members, Appeal Representatives and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Health Benefit Plan conducts an expedited internal review and issues a decision to the Member and their practitioner/provider within 48 hours of the date the Health Benefit Plan received the appeal. The notification includes the basis for the decision, and the procedure for obtaining an expedited external review.

The decision is final unless the Member chooses to appeal to the Pennsylvania Insurance Department or the Pennsylvania Department of Health as described in the decision letter. (See also "External Complaint Appeals" below.)

External Complaint Appeals

External Standard and Expedited Complaint Appeals
If the Member is not satisfied with the decision of the internal Second Level Complaint Committee or Expedited Complaint Committee, the Member has the right to an external appeal. The Member's external Complaint appeal is to be filed within **15 calendar days** of their receipt of the decision letter for a second level standard Complaint appeal and within **two business days** of the Member's receipt of the decision letter for an expedited Complaint appeal. The Member's request for an external Complaint appeal review is to be filed in writing to the Pennsylvania Insurance Department (PID) or Pennsylvania Department of Health (DOH) at the addresses noted below:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health and Welfare Bldg.
625 Forster Street
Harrisburg, PA. 17120-0701
Toll Free: 1-888-466-2787
1-717-787-5193
Fax: 1-717-705-0947

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA. 17120
1-877-881-6388
Fax: 1-717-787-8585

The Member's request for external review of their standard or expedited Complaint appeal should include the Member's name, address, daytime telephone number, the name of the Health Benefit Plan as their managed care plan, the group number, the Member's Health Benefit Plan ID number and a brief description of the issue being appealed. Also include a copy of the Member's original request for an internal second level standard or expedited Complaint appeal review to the Health Benefit Plan and copies of any correspondence and decision letters from the Health Benefit Plan.

When an external standard or expedited Complaint appeal request is submitted to the PID or DOH, the original submission date of the request is considered the date of receipt. The regulatory agency that receives the request will review it and transfer it to the other agency if this is found to be appropriate. The regulatory agency that handles the Member's external Complaint appeal will provide the Member and the Health Benefit Plan with a copy of the final determination of its decision.

GRIEVANCE APPEAL PROCESS

Formal Member Grievance Appeal Process for Decisions Based On Medical Necessity
Members may file a formal Grievance appeal of a decision by the Health Benefit Plan regarding a Covered Service that was denied or limited based primarily on Medical Necessity, the cosmetic or experimental/investigative exclusions, or other grounds that rely on a medical or clinical judgment.

The Grievance appeal process consists of two internal Grievance reviews by the Health Benefit Plan —a first level standard Grievance and second level standard Grievance—and an external review through an external certified review entity or utilization review agency assigned by the

Pennsylvania Department of Health (DOH).

There is also an internal and external expedited Grievance appeal process in the event the Member's condition involves an urgent issue.

Internal Grievance Appeals

Internal First Level Standard Grievance Appeals
The Member may file a first level standard Grievance appeal within **180 calendar days** from the date of receipt of the original denial by the Health Benefit Plan. To do so, call Customer Service at the toll free telephone number listed on their ID Card, or call, write or fax the Member Appeals Department as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

The Health Benefit Plan will acknowledge receipt of the Member's Grievance appeal in writing within **five business days** of receipt of the request.

The Member's first level standard Grievance appeal is reviewed by a Committee for which a plan Medical Director is the decision-maker. The decision-maker is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist or "same or similar specialty Physician" is a licensed Physician or Psychologist who:
- Is in the same or similar specialty as typically manages the care under review;
- Has had no previous involvement in the case; and,
- Is not a subordinate of the person who made the original determination.

The matched specialist must also hold an active license to practice medicine.

If the matched specialist Physician is a consultant, his or her opinion on the Grievance appeal issues will be reported to the Health Benefit Plan in writing for consideration by the Committee. The Member may request a copy of the matched specialist's opinion in writing, and when possible it will be provided to the Member at least seven calendar days prior to the date of review by the First Level Grievance Committee. The matched specialist's report includes his or her credentials as a licensed Physician or Psychologist such as board certification.

The First Level Grievance Committee completes its review of the Member's standard Grievance appeal within:
- **15 calendar days** from receipt of a Pre-service appeal; and
- **30 calendar days** from receipt of a Post-service appeal.

The Member will be sent the Committee's decision on their first level standard Grievance appeal in writing within the timeframes noted above. If the Member's Grievance appeal is denied, the decision letter states:
- The specific reason for the denial;
- The Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to appeal to the next level if the Member is not satisfied with the decision.

Internal Second Level Standard Grievance
If not satisfied with the decision from the Member's first level standard Grievance, the Member may file a second level standard Grievance appeal within **60 calendar days** of their receipt of the first level standard Grievance appeal decision from the Health Benefit Plan. To file a second level standard Grievance, call, write or fax the Member Appeals Department at the address and numbers listed above.

The Member has the right to present their Grievance appeal to the Committee in person or by way of a conference call. The Member's appeal can also be presented by their Provider or another Appeal Representative if the Member's authorization is obtained. (See **General Information About Member Appeal Processes** above for information about authorizations.)

The Second Level Grievance Committee for a standard Grievance appeal is composed of three persons who have had no previous involvement with the Member's case and who are not subordinate to the original reviewer. The Second Level Grievance Committee includes two Health Benefit Plan staff members; at least one of these Committee members is a plan Medical Director, a Physician who holds an active license. Additionally, one third of the Committee is not employed by the Health Benefit Plan.

Upon receipt of the Member's appeal, the Member will be notified in writing when possible **15 calendar days** in advance of a date and time scheduled for the Second Level Grievance Committee's meeting. The Member may request a change in the meeting schedule. The Health Benefit Plan will try to accommodate their request while remaining within the established timeframes. If the Member does not participate in the meeting, the Second Level Grievance Committee will review the Member's Grievance appeal and make its decision based on all available information.

The Second Level Grievance Committee will meet and render a decision on the Member's standard Grievance appeal within:
- **15 calendar days** from receipt of a Pre-service appeal; and
- **30 calendar days** from receipt of a Post-service appeal.

The Committee's review will include the matched specialist report. Upon written request, the Member will be provided with a copy of this report when possible within **at least seven calendar days** prior to the review by the Second Level Grievance Committee. The matched specialist's report includes his or her credentials as a licensed Physician or Psychologist such as board certification. If the matched specialist is attending the meeting, his/her credentials such as board certification will be provided to the Member. The Member may submit supporting materials both before and at the time of the appeal meeting. Additionally, the Member has the right to review all information considered by the Committee that is not confidential, proprietary or privileged.

The Second Level Grievance Committee meetings are a forum where Members each have the opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany the Member, unless the Member receives prior approval from the Health Benefit Plan for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's Appeal Representative or to provide general, personal assistance. Members may not audiotape or videotape the Committee proceedings.

The Member will be sent the decision of the Second Level Grievance Committee in writing

within the timeframes noted above. The decision is final unless the Member chooses to file an external standard Grievance within **15 calendar days** of their receipt of the decision notice from the Health Benefit Plan.

Internal Expedited Grievance Appeals
If the Member's case involves an urgent medical condition, then the Member or their Physician may ask to have the Member's case reviewed in a faster manner, as an Expedited Grievance. There is only one internal level of appeal review for an Expedited Grievance appeal.

Members with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an internal Expedited Grievance review by the Health Benefit Plan, call Customer Service at the toll free telephone number listed on the Member's ID card, or call, or fax the Member Appeals Department at the telephone numbers listed above. The Health Benefit Plan will promptly inform the Member whether their appeal request qualifies for expedited review or instead will be processed as a standard Grievance appeal.

The Expedited Grievance Committee has the same composition as a Second Level Grievance Committee for a standard Grievance appeal.

The Member has the right to present their Expedited Grievance to the Committee in person or by way of a conference call. The Member's appeal can also be presented by their Provider or another Appeal Representative if the Member's authorization is obtained. (See **General Information about Member Appeal Processes** above for information about authorizations.) If the Member does not participate in the meeting, the Expedited Grievance Committee will review their Grievance appeal and make its decision based on all available information.

The Expedited Grievance Committee meeting is a forum where Members have an opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany the Member unless the Member receives prior approval from the Health Benefit Plan for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as the Member's Appeal Representative or to provide general, personal assistance. Member Appeal Representatives and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Expedited Grievance review is completed promptly based on the Member's health condition. This Program conducts an expedited internal review and issues a decision to the Member and practitioner/provider within **48 hours** of the date the Health Benefit Plan received the appeal. The notification includes the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

External Grievance Appeals
The two types of external Grievance appeals—standard and expedited—are described below. Members are not required to pay any of the costs associated with the external standard or expedited Grievance appeal review. However, when a Provider is a Member's Appeal Representative for external Grievance appeal review, then the Provider is required to:

- Place in escrow one-half of the estimated costs of the external Grievance appeal process; and
- Pay the full costs for the external process if the Provider’s appeal on behalf of the Member is

not successful.

An independent certified review entity (CRE) assigned by the Pennsylvania Department of Health (DOH) reviews an external Grievance appeal. For standard and expedited Grievance appeals, the Health Benefit Plan authorizes the service(s) or pays claims, if the CRE decides that the requested care or services are Covered Services that are Medically Necessary. The Member is notified in writing of the time and procedure for claim payment or approval of the service(s) in the event that the CRE overturns the prior appeal decision. The CRE's decision may be appealed to a court of competent jurisdiction within **60 calendar days**.

External Standard Grievance Appeals
The Member has **15 calendar days** from the receipt of the decision letter for a second level standard Grievance to request an external standard Grievance appeal review. To file a request an external standard Grievance review by a DOH-assigned CRE, contact the Member Appeals Department as directed in the second level Grievance appeal decision letter or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276
Fax: 1-888-671-5274

The Member will be sent written acknowledgement that the Health Benefit Plan has received their external standard Grievance request from the Health Benefit Plan within **five business days** of its receipt of the Member's request. The Health Benefit Plan contacts the DOH to request assignment of a CRE to review the Member's Grievance. The Health Benefit Plan notifies the Member of the name, address and telephone number of the CRE assigned by the DOH to their Grievance within **two business days** of the Health Benefit Plan's receipt of the assignment from the Department. The Member and the Health Benefit Plan have **seven business days** to notify the DOH, if there is an objection to the assignment of the CRE on the basis of conflict of interest.

To submit additional information, the Member or their Appeal Representative should send it to the Health Benefit Plan at the address appearing above and to the CRE within **15 calendar days** of the Member's receipt of the Health Benefit Plan's letter acknowledging their external standard Grievance appeal request. The Health Benefit Plan forwards copies of the information used in reviewing the Member's internal Grievance appeal to the CRE and a list of those documents to the Member or their Appeal Representative within **15 calendar days** of its receipt of the Member's external standard Grievance review appeal.

The CRE will send the Member or the Member's Appeal Representative a written decision within **60 calendar days** of the date when the Member filed their request for an external review. The CRE issues its decision and follow-up occurs as described above in the introduction to this section.

External Expedited Grievance Appeals
The Member has **two business days** from the Member's receipt of the internal expedited Grievance appeal decision to contact the Health Benefit Plan at the telephone number and address listed above to request an external expedited Grievance appeal. The Health Benefit Plan forwards the Member's request to the DOH **within 24 hours,** which assigns a CRE within 24 hours. The Health Benefit Plan forwards a copy of the internal Grievance appeal case file to

the CRE on the next business day and the CRE issues a decision **within two business days** of receipt. The CRE issues its decision and follow-up occurs as described above in the introduction to this section.

OTHER COVERAGE

- Worker's Compensation
  Any benefits provided by Worker's Compensation are not duplicated by this Program.

- Medicare
  Any services paid or payable by Medicare when Medicare is:
  - Primary; or
  - Would have been primary if the Member had enrolled for Medicare, are not duplicated by this Program. For working Members over age 65, the primary payor will be determined in accordance with TEFRA or existing regulations regarding Medicare reimbursement.

NOTE: For more information regarding other coverage, see "Coordination Of Benefits" and "Subrogation".

INDEPENDENT CORPORATION

The Group Contract is between the Group and Keystone. Keystone is a controlled affiliate of Independence Blue Cross operating under a license from Blue Cross and Blue Shield Association (the "Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Keystone to use the familiar Blue Cross and Blue Shield words and symbols. Keystone, which is entering into the contract, is not contracting as an agent of the national Association. Only Keystone shall be liable to the Subscriber for any of the obligations as stated under the Group Master Contract. This paragraph does not add any obligations to the Contract.

If the Member has questions about any of the information in this Benefit Booklet, or needs assistance at any time, please feel free to contact Customer Services by calling the telephone number shown on the Member's ID Card.

IMPORTANT DEFINITIONS

The terms below have the following meaning when describing the benefits in this Benefit Booklet. They will be helpful to you (the Member) in fully understanding your benefits.

Accidental Injury

Injury to the body that is solely caused by an accident, and not by any other causes.

Accredited Educational Institution

- A publicly or privately operated academic institution of higher learning which:
- Provides recognized courses or a course of instruction.
- Confers any of the following, when a student completes the course of study:
  - A diploma;
  - A degree; or
  - Another recognized certification of completion.
- Is duly recognized, and declared as such, by the appropriate authority, as follows:
  - An authority of the state in which such institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to, colleges and universities; and technical or specialized schools.

Alcohol Or Drug Abuse And Dependency

Any use of alcohol or other drugs which produces a pattern of pathological use that:

- Causes impairment in the way people relate to others; or
- Causes impairment in the way people function in their jobs or careers; or
- Produces a dependency that makes a person physically ill, when the alcohol or drug is taken away.

Alcohol Or Drug Abuse And Dependency Treatment Facility

A facility which is licensed by the Department of Health as an alcoholism or drug addiction treatment program that is primarily engaged in providing Detoxification and rehabilitation treatment for Alcohol Or Drug Abuse And Dependency.

Allowed Amount

This refers to the basis on which a Member's Deductibles, Coinsurance, Out-of-Pocket Maximum and benefits are calculated.

- For services provided by a Participating Facility Provider, the term "Allowed Amount" means the lesser of the actual charge and the amount paid by the Health Benefit Plan under a special pricing arrangement with Participating Facility Provider(s) unless the a Participating Facility Provider's contractual arrangement with the Health Benefit Plan provides otherwise.
- For services provided by a Participating Professional Provider, "Allowed Amount" is the Health Benefit Plan’s fee schedule amount.
- For services provided by Participating Ancillary Providers, "Allowed Amount" means the amount that the Health Benefit Plan has negotiated with the Participating Ancillary Provider as total reimbursement for the Covered Services.

Alternative Therapies/Complementary Medicine

A group of diverse medical and health care systems, practices, and products which, at this time,

are not considered to be part of conventional medicine.

This is based on the definition from *The National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM).*

The NCCAM groups these therapies into the following five classifications:
- Alternative medical systems.(For example, homeopathy, naturopathy, Ayurveda, traditional Chinese medicine).
- Mind-body interventions: A variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms. (For example, meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance).
- Biologically based therapies. The use of natural substances such as herbs, foods, vitamins, or nutritional supplements to prevent and treat illness. (For example, macrobiotics, megavitamin therapy).
- Manipulative and body-based methods. (For example, massage, equestrian/hippotherapy).
- Energy therapies: Therapies involving the use of energy fields. They are of two types:
  - Biofield therapies: Therapies that are intended to affect energy fields that some claim surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. (For example, Qi Gong, Reiki, and therapeutic touch).
  - Bioelectromagnetic-based therapies: Therapies involving the unconventional use of electromagnetic fields. (For example, pulsed fields, magnetic fields, or alternating-current or direct-current fields).

Ambulatory Surgical Facility
An approved Facility Provider where the Member goes to have Surgery on an Outpatient basis, instead of having to be admitted to a Hospital.

It is a Facility Provider which:
- Has an organized staff of Physicians;
- Is licensed as required; and
- Has been approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- Has been approved by the Accreditation Association for Ambulatory Health Care, Inc., or
- By the Health Benefit Plan.

It is also a Facility Provider which:
- Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
- Provides treatment, by or under the supervision of Physicians and nursing services, whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Ancillary Service Provider
An individual or entity that provides Covered Services, supplies or equipment such as, but not limited to:
- Infusion Therapy Services;
- Durable Medical Equipment; and
- Ambulance services.

Anesthesia
The process of giving the Member an approved drug or agent, in order to:
- Cause the Member's muscles to relax;
- Cause the Member to lose feeling; or
- Cause the Member to lose consciousness.

Annual Benefit Maximum
- The maximum amount of benefits provided to a Member in each Benefit Period.
- This amount is shown in the ***Schedule of Covered Services***.
- It does not include the amount the Member pays for Covered Services in the form of:
  - Copayments;
  - Coinsurance; and/or
  - Deductibles.

Attention Deficit Disorder
A disease that makes a person have a hard time paying attention; be too impulsive; and be overly active.

Away From Home Care Coordinator
The staff whose functions include assisting members with registering as a Guest Member for Guest Membership Benefits under the Away From Home Care Program.

Away From Home Care Program
A program, made available to independent licensees of the Blue Cross Blue Shield Association, that provides Guest Membership Benefits to Members registered for the Program while traveling out of Keystone's Service Area for an extended period of time. The Away From Home Care Program offers portable HMO coverage to Members traveling in a Host HMO Service Area. Registration for Guest Membership Benefits under the Away From Home Care Program is coordinated by the Away From Home Care Coordinator.

Benefit Period
The specified period of time as shown in the ***Schedule of Covered Services*** within which the Member has to use Covered Services in order to be eligible for payment by their Health Benefit Plan. A charge shall be considered Incurred on the date the service or supply was provided to the Member.

Birth Center
A Facility Provider approved by the Health Benefit Plan which:
- Is primarily organized and staffed to provide maternity care;
- Is where a woman can go to receive maternity care and give birth;
- Is licensed as required in the state where it is situated; and
- Is under the supervision of a Physician or a licensed certified nurse midwife.

BlueCard Program
A program that enables Members obtaining health care services while traveling outside the Keystone Service Area to receive all the same benefits of their Program and access to BlueCard Traditional Providers and savings. The program links participating health care providers and the independent Blue Cross and Blue Shield Licensees across the country and also to some international locations through a single electronic network for claims processing

and reimbursement.

Brand Name Drug
A single source, FDA approved drug manufactured by one company for which there is no FDA approved substitute available. The term “Brand Name Drug” shall also mean devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

Case Management
Comprehensive Case Management programs serve Members who have been diagnosed with an illness or injury that is complex, catastrophic, or chronic.

The objectives of Case Management are to:
- Make it easier for Members to get the service and care they need in an efficient way;
- Link the Member with appropriate health care or support services;
- Assist Providers in coordinating prescribed services;
- Monitor the quality of services delivered; and
- Improve Members’ health outcomes.

Case Management supports Members and Providers by:
- Locating services;
- Coordinating services; and/or
- Evaluating services.

These steps are taken, across various levels and sites of care, for a Member who has been diagnosed with a complex, catastrophic or chronic illness and/or injury.

Certified Registered Nurse
Any one of the following types of nurses who are certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing:
- A certified registered nurse anesthetist;
- A certified registered nurse practitioner;
- A certified entreostomal therapy nurse;
- A certified community health nurse;
- A certified psychiatric mental health nurse; or
- A certified clinical nurse specialist.

This excludes any registered professional nurses employed by:
- A health care facility; or
- An anesthesiology group.

Cognitive Rehabilitative Therapy
A medically prescribed, multidisciplinary approach that consists of tasks that:
- Establish new ways for a person to compensate for brain function that has been lost due to injury, trauma, stroke, or encephalopathy; or
- Reinforce or re-establish previously learned patterns of behavior.

It consists of a variety of therapy modalities which lessen and ease problems caused by deficits in:
- Attention;
- Visual processing;
- Language;
- Memory;
- Reasoning; and
- Problem solving.

Cognitive rehabilitation is performed by any of the following professionals, using a team approach:
- A Physician;
- A neuropsychologist;
- A psychologist; as well as, a physical, occupational or speech therapist.

Coinsurance
A type of cost-sharing in which the Member assumes a percentage of the Health Benefit Plan's fee schedule amount for Covered Services (such as 20%). The Coinsurance percentage is listed in the ***Schedule of Covered Services.***

Compendia
Compendia are reference documents used by the Health Benefit Plan to determine if a Prescription Drug should be covered. Compendia provide:
- Summaries of how drugs work;
- Information about which drugs are recommended to treat specific diseases; and
- The appropriate dosing schedule for each drug.

Over the years, some compendia have merged with other publications. The Health Benefit Plan only reviews current compendia when making coverage decisions.

Complaint
A dispute or objection regarding coverage, including:
- Exclusions and non-Covered Services under the Program;
- Participating or Non-Participating Providers' status; or
- The operations or management policies of the Health Benefit Plan.

This definition does not include:
- A Grievance appeal (Medical Necessity appeal); or
- Disputes or objections that were resolved by the Health Benefit Plan and did not result in the filing of a Complaint appeal (written or oral).

Conditions For Departments (for Qualifying Clinical Trials)
The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:
- To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
- Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

Contraceptive Drugs
FDA approved drugs to be dispensed for the use of contraception. These include oral contraceptives, such as birth control pills, as well as injectable contraceptive drugs.

Contract (Group Master Contract)
It is the agreement between: The Health Benefit Plan and the Group.
The agreement includes:

- The Enrollment/Change Forms;
- Cover Sheet;
- Group Application;
- Acceptance Sheet;
- Schedules;
- Benefit Booklet;
- Riders; and/or
- Amendments ,if any.

It is also referred to as: The Group Contract.

Controlled Substance
Any medicinal substance as defined by the Drug Enforcement Administration which requires a Prescription Order in accordance with the Controlled Substance Act-Public Law 91-513.

Coordination of Benefits (COB)
A provision that is intended to avoid claims payment delays and duplication of benefits, when a person is covered by two or more Group plans that provide benefits or services for medical, dental or other care or treatment.
- It avoids claims payment delays by establishing an order in which plans pay their claims, and by providing the authority for the orderly transfer of information needed to pay claims promptly.
- It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the Rules established by this provision, that plan does not have to pay benefits first.
- This provision does not apply to:
  - Student accident plans paying $100 per day or less; or
  - Group hospital indemnity plans paying $100 per day or less.

Copayment
A specified dollar amount that is applied to a specific Covered Service for which the Member is responsible per Covered Service. Copayments, if any, are identified in the ***Schedule of Covered Services***.

Covered Drugs Or Supplies
Prescription Drugs, including Self-Administered Prescription Drugs, or supplies approved under Federal Law by the FDA for general use, and limited to the following:
- Prescription Drugs Prescribed by a Primary Care Physician or Referred Specialist subject to the ***Exclusions – What Is Not Covered*** section;
- Compounded Prescription Drugs containing at least one Legend Drug or Controlled Substance in an amount requiring a Prescription Order Or Refill;
- Insulin (by Prescription Order Or Refill only); or
- Spacers for metered dose inhalers (by Prescription Order Or Refill only).

Covered Service

A service or supply specified in this Benefit Booklet for which benefits will be provided by the Health Benefit Plan.

Custodial Care (Domiciliary Care)

Care provided primarily for Maintenance of the patient or care which is designed essentially:
- To assist the patient in meeting his activities of daily living; and
- Which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Custodial Care includes help in tasks which do not require the technical skills or professional

training of medical or nursing personnel in order to be performed safely and effectively.

Such tasks include, but are not limited to:
- Walking;
- Bathing;
- Dressing;
- Feeding;
- Preparation of special diets; and;
- Supervision over self-administration of medications.

Day Rehabilitation Program

A level of Outpatient Care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week.

The Member returns Home:
- Each evening; and
- For the entire weekend.

Therapies provided may include a combination of therapies, such as:
- Physical Therapy;
- Occupational Therapy; and
- Speech Therapy.

Other medical services such as:
- Nursing services;
- Psychological therapy; and
- Case Management services.

Day Rehabilitation sessions also include a combination of:
- One-to-one therapy; and
- Group therapy.

Decision Support

Services that help members make well-informed decisions about health care and support their ability to follow their Participating Provider's treatment plan. Some examples of support services are:
- Major treatment choices; and
- Every day health choices.

Dental Emergency

An acute condition occurring suddenly and unexpectedly, which usually includes:
- Pain;
- Swelling or bleeding; and
- Demands immediate professional dental services.

Dentally Necessary

A dental service or procedure is determined by a Dentist to either:
- Establish; or
- Maintain a patient's dental health.
  This is based on the professional diagnostic judgment of the:

- Dentist; and
- Prevailing standards of care in the professional community.

The determination will be made by the Dentist in accordance with: Guidelines established by the Health Benefit Plan.

When there is a conflict of opinion between the Dentist and the Health Benefit Plan on whether or not a dental service or procedure is Dentally Necessary: The opinion of the Health Benefit Plan will be final.

The Member shall be held harmless if: After receiving services from a Primary Dentist or Specialty Care Dentist, such services are determined not Dentally Necessary.

Dependent

An individual, who relies on the Member for some level of aid and support and:

- Who resides in the Service Area;
- For whom Medicare is not primary pursuant to any federal or state regulation, law or ruling;
- Who is enrolled under the Health Benefit Plan coverage; and
- Who meets all of the eligibility requirements established by the Group and the Health Benefit Plan as described in the Eligibility section of the ***General Information*** section of this Benefit Booklet.

Designated Provider

A Participating Provider with whom the Health Benefit Plan has contracted the following outpatient services:

- Certain rehabilitation Therapy Services (other than Speech Therapy);
- Diagnostic radiology services for Members age five or older; or
- Laboratory and pathology tests.

The Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

Detoxification

The process by which a person who is alcohol or drug intoxicated, or alcohol or drug dependent, is assisted under the following circumstances:

- In a state licensed Facility Provider; or
- In the case of opiates, by an appropriately licensed behavioral health provider, in an ambulatory
  (Outpatient) setting.

This treatment process will occur through the period of time necessary to eliminate, by metabolic or other means, any or each of the following problems:

- The intoxicating alcohol or drug;
- Alcohol or drug dependency factors; or
- Alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

Disease Management

An approved program designed to identify and help people, who have a particular chronic disease, to stay as healthy as possible

- Disease Management programs use a population-based approach to:
  - Identify Members who have or are at risk for a particular chronic medical condition;
  - Intervene with specific programs of care; and
  - Measure and improve outcomes.
- Disease Management programs use evidence-based guidelines to:
  - Educate and support Members and PCP's and Participating Professional Providers;
  - Matching interventions to Members with greatest opportunity for improved clinical or functional outcomes.
- To assist Members with chronic disease(s), Disease Management programs may employ:
  - Education;
  - Provider feedback and support statistics;
  - Compliance monitoring and reporting; and/or
  - Preventive medicine.
- Disease Management interventions are intended to both:
  - Improve delivery of services in various active stages of the disease process; as well as to reduce/prevent relapse or acute exacerbation of the condition.

Domestic Partner (Domestic Partnership)

If applicable, an individual of a Domestic Partnership consisting of two people each of whom:
- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other partner by adoption or blood;
- Is the sole Domestic Partner of the other partner, with whom the person has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and
- Demonstrates financial interdependence by submission of proof of three or more of the following documents:
  - A Domestic Partnership agreement;
  - A joint mortgage or lease;
  - A designation of one of the partners as beneficiary in the other partner's will;
  - A durable property and health care powers of attorney;
  - A joint title to an automobile, or joint bank account or credit account; or
  - Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

The Health Benefit Plan reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

Drug Formulary

A listing of Prescription Drugs preferred for use by the Health Benefit Plan. This list shall be subject to periodic review and modification by the Health Benefit Plan. Covered Drugs not listed in the Drug Formulary shall be subject to the Non-Formulary Drug cost share.

Durable Medical Equipment (DME)

Equipment that meets the following criteria:
- It is durable. (This is an item that can withstand repeated use.)

- It is medical equipment. (This is equipment that is primarily and customarily used for medical purposes, and is not generally useful in the absence of illness or injury.)
- It is generally not useful to a person without an illness or injury.
- It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to:

- Diabetic supplies;
- Canes
- Crutches;
- Walkers;
- Commode chairs;
- Home oxygen equipment;
- Hospital beds;
- Traction equipment; and
- Wheelchairs.

Effective Date

The date on which coverage for a Member begins under the Program. All coverage begins at 12:01 a.m. on the date reflected on the records of the Health Benefit Plan.

Emergency Services (Emergency)

Any health care services provided to a Member after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency transportation and related Emergency Service provided by a licensed ambulance service shall constitute an Emergency Service.

Employee

An individual of the Group contracting with the Health Benefit Plan and:

- Who meets the eligibility requirements for enrollment;
- Who, at enrollment, is specified as meeting the eligibility requirements; and
- In whose name the Identification Card is issued.

Enrollment/Change Form

The properly completed, written request for enrollment for Program membership:

- Submitted in a format provided by the Health Benefit Plan; and
- Together with any amendments or modifications to that written request.

Experimental Or Investigational Drugs

Pharmacological regimens not generally accepted by the American medical community or approved by the FDA.

Experimental/Investigative

A drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

- Is the subject of ongoing clinical trials;
- Is the research, experimental, study or investigational arm of an on-going clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

- Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
- Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process (For example: An Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:

- Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.
- Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
- Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

Facility Provider

An institution or entity licensed, where required, to provide care.

Such facilities include:

- Ambulatory Surgical Facility;
- Birth Center;
- Free Standing Dialysis Facility;
- Free Standing Ambulatory Care Facility;
- Home Health Care Agency;
- Hospice;
- Hospital;
- Non-Hospital Facility;
- Psychiatric Hospital;
- Rehabilitation Hospital;
- Residential Treatment Facility;
- Short Procedure Unit;
- Skilled Nursing Facility.

Follow-Up Care
Care scheduled for Medically Necessary follow-up visits that occur while the Member is away from home.
- Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is still at home. An example is Dialysis.
- Follow-Up Care must be Preapproved by the Member's Primary Care Physician prior to traveling.

This service is available through the BlueCard Program for temporary absences (less than 90 consecutive days) from Keystone's Service Area.

Free Standing Ambulatory Care Facility
A Facility Provider, other than a Hospital, that provides treatment or services on an Outpatient or partial basis.

In addition, the facility:
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician.
- Is licensed by the state in which it is located and be accredited by the appropriate regulatory body.

Free Standing Dialysis Facility
A Facility Provider that provides dialysis services for people who have serious kidney disease.

In addition, the facility:
- Is primarily engaged in providing dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.
- Is licensed or approved by the appropriate governmental agency; and
- Is approved by the Health Benefit Plan.

Generic Drug
Pharmacological agents approved by the FDA as a bioequivalent substitute and manufactured by a number of different companies as a result of the expiration of the original patent.

Grievance
A request by the Member or a health care Provider with the written consent of the Member to have the Health Benefit Plan reconsider a decision made to deny coverage for a service or a supply solely concerning the Medical Necessity or appropriateness of a health care service.

The request for reconsideration:
- Can be made by a Member;
- Can also be made by a health care Provider, on the Member's behalf, with the Member's written consent; and
- Is made to have the Health Benefit Plan reconsider a decision, solely based on the Medical Necessity or appropriateness of a health care service.

This definition does not include:
- A Complaint appeal; and
- Disputes or objections regarding Medical Necessity that were resolved by the Health Benefit Plan, and did not result in the filing of a Grievance appeal (written or oral).

Group (Contract Holder)
The entity which established, sponsors, and/or maintains a welfare benefit plan for the purpose of providing health insurance benefits to plan participants or their beneficiaries, and which, on behalf of the welfare benefit plan, has agreed to remit payments to the Health Benefit Plan and to receive, on behalf of the enrolled Members, any information from the Health Benefit Plan related to the benefits provided to enrolled Members pursuant to the terms of the Contract.

Group Contract - see Contract

Guest Member
A Member who has a pre-authorized Guest Member registration in a Host HMO Service Area for a defined period of time.

After that period of time has expired the Member must again meet the eligibility requirements for Guest Membership Benefits, under the Away From Home Care Program and re-enroll as a Guest Member to be covered for those benefits.

A Subscriber's eligible Dependent may register as a 'Student Guest Member.
- The Dependent must be a student residing outside Keystone's Service Area and inside a Host HMO Service Area.
- The Dependent student must not be residing with the Subscriber and must be residing in a Host HMO Service Area.

Guest Membership (Guest Membership Program)
A program that provides Guest Membership Benefits to Members while traveling out of the Keystone's Service Area for a period of at least 90 consecutive days.

Guest Membership Overview
- Guest Membership Benefits provide coverage for a wide range of health care services.
- The Guest Membership Program offers portable HMO coverage to Members of plans contracting in Keystone's network.
- Services provided under the Guest Membership Program are coordinated by the Guest Membership Coordinator.
- Guest Membership is available for a limited period of time.

The Guest Membership Coordinator will confirm the period for which a Member is registered as a Guest Member.

Guest Membership Benefits
Benefits available to Members while traveling out of Keystone's Service Area, for a period of at least 90 consecutive days
- Guest Membership Benefits provide coverage for a wide range of health care services.
- Members can register for Guest Membership Benefits available under the Away From Home Care Program, by contacting the Away From Home Care Coordinator.
- The Away From Home Care Coordinator will also confirm the period for which the Member is registered as a Guest Member, since Guest Membership Benefits are available for a limited period of time.

Guest Membership Coordinator
The staff that assists Members with registration for Guest Membership, and provides other assistance to Members while Guest Members.

Habilitation Therapy (Habilitative Services)
Includes treatments designed to enable a Member with a disability to attain, improve, and retain skills and functioning for daily living.

Hearing Aid
A Prosthetic Device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of:
- A microphone to pick up sound;
- An amplifier to increase the sound;
- A receiver to transmit the sound to the ear; and
- A battery for power.

A Hearing Aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a Hearing Aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles:
- Behind-The-Ear;
- In-The-Ear;
- In-The-Canal;
- Completely-In-The-Canal; or
- Implantable (Can Be Partial or Complete).

A Hearing Aid is not a cochlear implant.

Home
For purposes of the Home Health Care and Homebound Covered Services only, this is the place where the Member lives.

This place may be:
- A private residence/domicile;
- An assisted living facility;
- A long-term care facility; or
- A Skilled Nursing Facility at a custodial level of care.

Home Health Care Provider
A licensed Provider that provides home health care Covered Services to Members.
Services are provided:
- On an intermittent basis in the Member's Home;
- In accordance with an approved home health care Plan Of Treatment; and
- Based on an agreement entered into with the Health Benefit Plan.

Homebound

Being unable to safely leave Home due to severe restrictions on the Member's mobility.

A person can be considered Homebound when leaving Home would do the following:
- Involve a considerable effort by the Member; and
- Leave the Member unable to use transportation, without another's assistance.

The following individuals will NOT automatically be considered Homebound, but must meet both requirements above:
- A child
- An unlicensed driver; or
- An individual who cannot drive.

Hospice
A Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals.

The Hospice must be:
- Certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and
- Appropriately licensed in the state where it is located.

Hospice Provider
Licensed Provider that is primarily engaged in providing care to terminally ill people whose estimated survival is six months or less.

Hospice Care is primarily comfort care and includes:
- Relief of pain;
- Management of symptoms; and
- Supportive services that will help the Member cope with a terminal illness rather than cure it.

Covered Services to be provided by the Hospice Provider include Home Hospice and/or Inpatient Hospice services that have been referred by the Member's Primary Care Physician and Preapproved by the Health Benefit Plan.

Hospital
An approved facility that provides Inpatient, as well as Outpatient Care, and that meet the requirements listed below.

The term Hospital specifically refers to a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations; and/or by the American Osteopathic Hospital Association or by the Health Benefits Plan, and which meets the following requirements:
- Is a duly licensed institution;
- Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- Has organized departments of medicine;
- Provides 24-hour nursing service by or under the supervision of Registered Nurses;
- Is not, other than incidentally, any of the following:
  - Skilled Nursing Facility;
  - Place for rest;

- Nursing home;
- school;
- Custodial Care home;
- Health resort;
- Spa or sanitarium;
- Place for provision of rehabilitation care;
- Place for treatment of pulmonary tuberculosis;
- Place for aged;
- Place for treatment of Mental Illness;
- Place for treatment of Alcohol or Drug Abuse;
- Place for provision of Hospice care.

Hospital-Based Provider

A Physician who provides Medically Necessary services in a Hospital or other Participating Facility Provider and meets the requirements listed below:

- The Medically Necessary services must be supplemental to the primary care being provided in the Hospital or Participating Facility Provider ;
- The Medically Necessary services must be those for which the Member has limited or no control of the selection of such Physician;
- Hospital-Based Providers include Physicians in the specialties of:
  - Radiology;
  - Anesthesiology;
  - Pathology; and/or
  - Other specialties, as determined by the Health Benefit Plan.

When these Physicians provide services other than in the Hospital or other Participating Facility, they are not considered Hospital-Based Providers.

Hospital Services

Health care services that (except as limited or excluded herein) are all of the following:

- Are acute-care Covered Services, provided in a Hospital, which are Referred by the Member's Primary Care Physician or provided by the Member's Referred Specialist and Preapproved by the Health Benefit Plan where required; and
- Are listed in the Description of Covered Services.

Host HMO

The contracting HMO through which a Member can receive Away From Home Care Covered Services as a Guest Member when traveling in the Host HMO Service Area.

Host HMO Service Area

Host HMO's approved geographical area within which the Host HMO is approved to provide access to Covered Services.

Identification Card (ID Card)

The currently effective card issued to the Member by the Health Benefit Plan which must be presented when a Covered Service is requested.

Immediate Family

The Employee's:

- Spouse;
- Parent;
- Child, stepchild;
- Brother, sister;
- Mother-in-law, father- in-law;
- Sister-in-law, brother- in-law;
- Daughter- in-law, son-in-law.

Immunizations

Medication that helps protect a person from certain infections. All Immunizations must conform to the standards set by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.

Coverage for routine Immunizations is provided for adult and pediatric Members (limited to Members under 21 years of age).

For routine immunizations, the Health Benefit Plan provides coverage for
- The administration of the Immunization, and
- The agent used for Immunization.

The Health Benefit Plan does not provide coverage for:
- Employment-related Immunizations;
- Travel-related Immunizations; and
- Immunizations that are not recommended by the ACIP.

ACIP Immunization schedules can be found at:
http://www.cdc.gov/vaccines/schedules/index.html

Incurred

A charge shall be considered Incurred (acquired) on the date a Member receives the service or supply for which the charge is made.

Independent Clinical Laboratory

A laboratory that performs clinical pathology procedure and that is not affiliated or associated with a:
- Hospital;
- Physician; or
- Facility Provider.

Inpatient Admission (Inpatient)

The actual entry of a Member, who is to receive Inpatient services as a registered bed patient, and for whom a room and board charge is made, into any of the following:
- Hospital;
- Extended care facility; or
- Facility Provider.

The Inpatient Admission shall continue until such time as the Member is actually discharged from the facility.

Inpatient Care

Treatment received as a bed patient in a:
- Hospital
- Rehabilitation Hospital

- Skilled Nursing Facility; or
- Participating Facility Provider that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider

In-Network Dentist
A Primary Dental Office or a Specialty Care Dentist.

Intensive Outpatient Program
A planned, structured program that coordinates and uses the services of various health professionals, to treat patients in crisis who suffer from:
- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency.

Intensive Outpatient Program treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until they are able to transition to less intensive Outpatient treatment, as required.

Keystone Health Plan East, Inc. ("Keystone" or "The Health Benefit Plan")
A health maintenance organization providing access to comprehensive health care to Members.

Legend Drug
An FDA approved drug which:
- Requires a prescription; and
- Must be labeled by the Federal Drug and Cosmetic Act with the words, "Caution: Federal law prohibits dispensing without a prescription."

Licensed Clinical Social Worker
A social worker who has:
- Has graduated from a school accredited by the Council on Social Work Education with a Doctoral or Master's Degree; and
- Is licensed by the appropriate state authority.

Licensed Practical Nurse (LPN)
A nurse who:
- Has graduated from a formal practical or nursing education program; and
- Is licensed by the appropriate state authority.

Life-Threatening Condition
For Qualifying

Clinical Trials this means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Limitations
The maximum number of Covered Services that are eligible for coverage.
- The maximum number of Covered Services can be measured as:
  - Hours;
  - Visits;

  - Days; or the
  - Dollar amount.
- Limitations may vary depending on the type of program and Covered Services provided.
- Limitations, if any, are identified in the ***Schedule of Covered Services***.

Limiting Age for Dependents
The age as shown below, at which a Dependent child is no longer eligible as a Dependent under the Subscriber's coverage. A Dependent child shall be removed from the Subscriber's coverage on the first of the month following the month in which the Subscriber's Dependent child reaches the Limiting Age for Dependents.

The Limiting Age for Dependents is: 26

Maintenance
A continuation of the Member's care and management when:
- The maximum therapeutic value of a Medically Necessary treatment plan has been achieved;
- No additional functional improvement is apparent or expected to occur;
- The provision of Covered Services for a condition ceases to be of therapeutic value; and
- It is no longer Medically Necessary.

This includes Maintenance services that seek to:
- Prevent disease;
- Promote health; and
- Prolong and enhance the quality of life.

Maintenance Prescription Drug
A Prescription Drug, as determined by the Health Benefit Plan, used for the treatment of chronic or long term conditions including, but not limited to:
- Cardiac disease;
- Hypertension;
- Diabetes;
- Lung disease; and
- Arthritis.

Masters Prepared Therapist
A therapist who:
- Holds a Master's Degree in an acceptable human services-related field of study;
- Is licensed as a therapist at an independent practice level; and
- Is licensed by the appropriate state authority to provide therapeutic services for the treatment of Mental health care and Serious Mental Illness health care.

Medical Care

Services rendered by a Participating Professional Provider for the treatment of an illness or injury. These are services that must be rendered within the scope of their license.

Medical Director

A Physician designated by the Health Benefit Plan to:
- Design and implement quality assurance programs; and
- Monitor utilization of health services by Members.

Medical Foods
Liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

Medical Policy
Medical Policy is used to determine whether Covered Services are Medically Necessary. Medical Policy is developed based on various sources including, but not limited to:
- Peer-reviewed scientific literature published in journals and textbooks; and
- Guidelines put forth by governmental agencies; and
- Respected professional organizations; and
- Recommendations of experts in the relevant medical specialty.

Medical Screening Evaluation
An examination and evaluation within the capability of the Hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel.

Medical Technology Assessment
The review and evaluation of available clinical and scientific information from expert sources. These sources include, and are not limited to:
- Publications from government agencies;
- Peer-reviewed journals;
- Professional guidelines;
- Regional and national experts;
- Clinical trials; and
- Manufacturers' literature.

The Health Benefit Plan uses the technology assessment process to assure that new drugs, procedures or devices are safe and effective before approving them as a Covered Service.

When new technology becomes available or at the request of a practitioner or Member:
- The Health Benefit Plan researches all scientific information available from these expert sources.
- Following this analysis, the Health Benefit Plan:
  - Makes a decision about when a new drug, procedure or device has been proven to be safe and effective; and
  - Uses this information to determine when an item becomes a Covered Service.

Medically Necessary (Medical Necessity)
Shall mean:
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of:
  - Preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient, that are:
  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
  - Not primarily for the convenience of the patient, Physician, or other health care provider;

and
  - Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on:
  - Credible scientific evidence, published in peer-reviewed medical literature that is generally recognized by the relevant medical community, Physician Specialty Society recommendations;
  - The views of Physicians practicing in relevant clinical areas; and
  - Any other relevant factors.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

A Subscriber or Dependent who meets the eligibility requirements for enrollment by the Group.

A Member does NOT mean any person who is eligible for Medicare, except as specifically stated in
this Benefit Booklet.

Mental Illness

Any of various conditions, wherein mental treatment is provided by a qualified Mental Health Provider.

- These various conditions must be categorized as mental disorders by the most current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM).
- For purposes of this Program, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness.
- The benefit limits for Mental Illness and Serious Mental Illness are separate and not cumulative.

Non-Formulary Drug

A Prescription Drug not included in the Drug Formulary.

Non-Hospital Facility

A Facility Provider, licensed by the Department of Health for the care or treatment of Members diagnosed with Alcohol or Drug Abuse And Dependency. This does NOT include transitional living facilities.

Non-Hospital Facilities shall include, but not be limited to the following, for Partial Hospitalization Programs:

- Residential Treatment Facilities; and
- Free Standing Ambulatory Care Facilities.

Non-Participating Pharmacy

A pharmacy (whether a retail or mail service pharmacy) which has not entered into a written

agreement with the Health Benefit Plan or an agent of the Health Benefit Plan to provide Covered Drugs Or Supplies to Members.

Non-Participating Provider

A Facility Provider, Professional Provider, Ancillary Service Provider that is NOT a member of the Health Benefit Plan's network.

Nutritional Formula

Liquid nutritional products which are formulated to supplement or replace normal food products.

Office Visits

Covered Services provided in the Physician's office and performed by or under the direction of:

- The Primary Care Physician; or
- A Participating Professional Provider.

Orthoptic/Pleoptic Therapy

Medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth percept ion.

Such dysfunction results from:

- Vision disorder;
- Eye Surgery; or
- Injury.

Treatment involves a program which includes evaluation and training sessions.

Out-Of-Network Dentist

A general or specialty care Dentist who has not signed a contract with the Health Benefit Plan. Also referred to as "Non-Participating Provider."

Out of Pocket Maximum

The maximum dollar amount that a Member pays for Covered Services under this Benefit Booklet in each Benefit Period as shown in the ***Schedule of Covered Services***. The Out-of-Pocket Maximum includes Copayments, Deductibles, and Coinsurance. It does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Benefit Booklet.

Outpatient Care (or Outpatient)

Medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a Hospital or other Inpatient Facility.

Outpatient Diabetic Education Program

An Outpatient Diabetic Education Program, provided by a Participating Professional Provider that has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

Outpatient Mental Health Care

Outpatient Serious Mental Illness Health Care

Outpatient Alcohol Or Drug Abuse And Dependency Treatment (Outpatient Treatment)

The provision of medical, nursing, counseling or therapeutic Covered Services:

- On a planned and regularly scheduled basis;
- At a Participating Facility Provider licensed by the Department of Health as:
  - An Alcohol Or Drug Abuse And Dependency treatment program; or
  - Any other mental health or Serious Mental Illness therapeutic modality, designed for a patient or Member who does not require care as an Inpatient.
- Outpatient Treatment includes: Care provided under a Partial Hospitalization program or an Intensive Outpatient Program. Each Outpatient visit or session is subject to:
  - The applicable Outpatient Mental Health Care Visits/Sessions cost sharing;
  - Outpatient Serious Mental Illness Health Care Visits/Sessions cost sharing; or
  - Outpatient Alcohol Or Drug Abuse And Dependency Treatment Visits/Sessions cost sharing.

Partial Hospitalization

Medical, nursing, counseling or therapeutic services that are:

- Provided on a planned and regularly scheduled basis in a Hospital or Facility Provider,
- Designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment (Intensive Outpatient Program or Outpatient Office Visit) but who does not require Inpatient confinement.

Participating Facility Provider

A Facility Provider that is a member of the Health Benefit Plan's network.

Participating Mail Service Pharmacy

A registered, licensed pharmacy with whom the Health Benefit Plan or an agent of the Health Benefit Plan has contracted to provide Covered Drugs Or Supplies through the mail and to accept as payment in full the Health Benefit Plan payment plus any applicable Prescription Drug cost sharing amount for the Covered Drugs Or Supplies.

Participating Pharmacy

Any registered, licensed pharmacy other than a Participating Mail Service Pharmacy with whom the Health Benefit Plan or an agent of the Health Benefit Plan has contracted to dispense Covered Drugs Or Supplies to Members and to accept as payment in full the Health Benefit Plan payment plus any applicable Prescription Drug cost sharing amount for the Covered Drugs Or Supplies.

Participating Professional Provider

A Professional Provider who is a member of the Health Benefit Plan's network.

Participating Provider

A Facility Provider, Professional Provider, or Ancillary Services Provider with whom the Health Benefit Plan has contracted directly or indirectly and, where applicable, is Medicare certified to render Covered Services. This includes but is not limited to:

- Primary Care Physician (PCP)
  A Participating Provider selected by a Member who is responsible for providing all primary

care Covered Services and for authorizing and coordinating all covered Medical Care, including Referrals for Specialist Services.

- Referred Specialist
  A Provider who provides Covered Specialist Services within his/her specialty and upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services, Referral to a Non-Participating Provider will be arranged by the Member's Primary Care Physician with Preapproval by the Health Benefit Plan. See ***Access To Primary, Specialist, and Hospital Care*** in the ***General Information*** section for procedures for obtaining Preapproval for use of a Non-Participating Provider.

- A Referred Specialist also includes Participating Professional Providers that provide the following designated services without a Referral:
  – Care from a Participating obstetrical/gynecological specialist; and
  – Dialysis.

  For the following Outpatient services, the Referred Specialist is the Member's Primary Care Physician's Designated Provider:
  – Certain rehabilitation Therapy Services (other than Speech Therapy);
  – Certain diagnostic radiology services for Members are age five or older; or
  – Laboratory and pathology tests. The Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

- Obstetricians and Gynecologists
  A Participating Provider selected by a female Member who provides Covered Services without a Referral. All non-facility obstetrical and gynecological Covered Services are subject to the same Copayment that applies to Office Visits to the Member's PCP.

  Participating obstetricians and gynecologists have the same responsibilities as Referred Specialists. For example, seeking Preapproval for certain services.

  Similarly, just as the Member has the right to designate a Referred Specialist as the Member's PCP, the Member may designate a participating obstetrician or gynecologist as the Member's PCP.

- Participating Hospital
  A Hospital that has contracted with the Health Benefit Plan to provide Covered Services to Members.

- Durable Medical Equipment (DME) Provider
  A Participating Provider of Durable Medical Equipment that has contracted with the Health Benefit Plan to provide Covered Supplies to Members.

- Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider
  A Provider in a network made up of professionals and facilities contracted by a behavioral health management company on the Health Benefit Plan's behalf to provide behavioral health/ Alcohol Or Drug Abuse And Dependency Covered Services for the treatment of Mental Illness, Serious Mental Illness and Alcohol Or Drug Abuse And Dependency, (including Detoxification) to Members. Licensed Clinical Social Workers and Masters

Prepared Therapists are contracted to provide Covered Services for treatment of mental health care and Serious Mental Illness only.

- Hospice Provider
  A licensed Participating Provider that is primarily engaged in providing pain relief, symptom management, and supportive services to a terminally ill Member with a medical prognosis of six months or less.

Pervasive Developmental Disorders (PDD)
Disorders characterized by severe and pervasive impairment in several areas of development:
- Reciprocal social interaction skills;
- Communication skills; or
- The presence of stereotyped behavior, interests and activities.

Examples are:
- Asperger's syndrome; and
- Childhood disintegrative disorder.

Pharmacist
An individual, who is duly licensed as a Pharmacist by:
- The State Board of Pharmacy; or
- Other governing body having jurisdiction.

An individual, who also is:
- Employed by a pharmacy; or
- Associated with a pharmacy.

Pharmacy and Therapeutics Committee
A group composed of health care professionals with recognized knowledge and expertise in: Clinically appropriate prescribing, dispensing and monitoring of Outpatient drugs or drug use review, evaluation and intervention.

The membership of the committee consists of at least two-thirds licensed and actively practicing Physicians; and Pharmacists and shall consist of at least one Pharmacist.

Physician
A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), and is licensed and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

Plan Of Treatment
A plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan Of Treatment should include goals and duration of treatment, and be limited in scope and extent to that care which is Medically Necessary for the Member's diagnosis and condition.

Preapproved (Preapproval) (Drug)
The approval which the Primary Care Physician or Referred Specialist must obtain from the Health Benefit Plan to confirm the Health Benefit Plan coverage for certain Covered Drugs Or Supplies for a Member's medical condition. Such Preapproval must be obtained prior to providing the Covered Drug Or Supply. The Health Benefit Plan also reserves the right to apply

eligible dispensing limits for certain Covered Prescription Drugs Or Supplies as conveyed by the FDA or the Health Benefit Plan's Pharmacy and Therapeutics Committee. The Member may call Customer Service at the telephone number shown on the ID Card to find out if the Covered Drug Or Supply has been approved by the Health Benefit Plan or may ask the Primary Care Physician to call Provider Services.

Preapproved (Preapproval) (Medical)

The approval which the Primary Care Physician or Referred Specialist must obtain from the Health Benefit Plan to confirm the Health Benefit Plan coverage for certain Covered Services. Such approval must be obtained prior to providing Members with Covered Services or Referrals. Approval will be given by the appropriate Health Benefit Plan staff, under the supervision of the Medical Director. If the Primary Care Physician or Participating Professional Provider is required to obtain a Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment. Preapproval is not required for a maternity Inpatient Admission. To access a complete list of services that require Preapproval, log onto , or the Member can call Customer Service at the phone number listed on the Member's ID card to have the list mailed to the Member.

Prenotification (Prenotify)

The requirement that a Member provide prior notice to the Health Benefit Plan that proposed services, such as maternity care, are scheduled to be performed.

- No Penalty will be applied for failure to comply with this requirement.
- Payment for services depends on whether the Member and the category of service are covered under this Program.
- To Prenotify, the Member should call the telephone number on the ID card, prior to obtaining the proposed service.

Prescribe or Prescribed

To write or give a Prescription Order.

Prescription Drug

A Legend Drug or Controlled Substance, which:

- Has been approved by the Food and Drug Administration(FDA) for a specific use; and
- Can, under federal or state law, be dispensed only pursuant to a Prescription Order.

To find out if the Member's Prescription Drug has been approved by the Health Benefit Plan:

- Call Customer Service at the telephone number shown on the Member's ID Card ;or
- Ask the Member's Primary Care Physician to call Provider Services.

Prescription Drug Copayment (Drug Copay)

The amount shown in the Schedule of Covered Services charged to the Member by the Participating Pharmacy or Participating Mail Service Pharmacy for the dispensing or refilling of any Prescription Order Or Refill. The Member is responsible at the time of service for payment of the Drug Copay directly to the Participating Pharmacy or Participating Mail Service Pharmacy.

Prescription Order (**Prescription Order Or Refill)**

The authorization for:

- A Prescription Drug, or
- Services or supplies prescribed for the diagnosis or treatment of an illness, which are issued by a Primary Care Physician or Referred Specialist who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

Primary Dental Office
Approved office of a Primary Dentist who has executed a contract with the Health Benefit Plan to offer Covered Services to Members.

Primary Dentist
A general Dentist whose office has:
- Executed a contract with the Health Benefit Plan;
  - Under which the Dentist agrees to provide Covered Services to Members;
    - For a monthly fee plus any applicable supplements and Copayments, as payment in full for services rendered.

Private Duty Nursing
Private Duty Nursing is Medically Necessary, complex skilled nursing care provided in the Member's private residence by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). It provides continuous monitoring and observation of a Member who requires frequent skilled nursing care on an hourly basis. Private Duty Nursing must be ordered by a Professional Provider who is involved in the oversight of the Member's care, in accordance with the Provider's scope of practice.

Professional Provider

A person or practitioner licensed, where required, and performing services within the scope of such licensure. The Professional Providers are:
- Audiologist;
- Certified Registered Nurse;
- Chiropractor;
- Dentist;
- Independent Clinical Laboratory;
- Licensed Clinical Social Worker;
- Master's Prepared Therapist;
- Nurse Midwife;
- Optometrist;
- Physical Therapist;
- Physician;
- Podiatrist;
- Psychologist;
- Registered Dietitian;
- Speech-Language Pathologist;
- Teacher of the hearing impaired.

Program
The benefit plan provided by the Group through an arrangement with the Health Benefit Plan.

Prosthetic Devices

Devices (except dental Prosthetics Devices), which replace all or part of:
- An absent body organ including contiguous tissue; or
- The function of a permanently inoperative or malfunctioning body organ.

Provider

Any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to:

- Physician;
- Group of Physicians;
- Allied health professional;
- Certified nurse midwife;
- Hospital;
- Skilled Nursing Facility;
- Rehabilitation Hospital;
- Birthing facility; or
- Home Health Care Provider.

In addition, for Mental Health Care and Serious Mental Illness services only, the following are authorized to render mental health care services and are also considered Providers:
- Licensed Clinical Social Worker; and
- Masters Prepared Therapist.

Psychiatric Hospital

A Facility Provider, approved by the Health Benefit Plan, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness.
- Such services are provided by or under the supervision of an organized staff of Physicians.
- Continuous nursing services are provided under the supervision of a Registered Nurse.

Psychologist

A Psychologist who is:
- Licensed in the state in which he practices; or
- Otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

Qualified Individual (for Clinical Trials)
A Member who meets the following conditions:
- The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and
- Either:
  - The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Member's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or
  - The Member provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Member meeting the conditions described above.

Qualifying Clinical Trial
A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:
- Federally funded trials: The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - The National Institutes of Health (NIH);
  - The Centers for Disease Control and Prevention (CDC);
  - The Agency for Healthcare Research and Quality (AHRQ);
  - The Centers for Medicare and Medicaid Services (CMS);
  - Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - Any of the following, if the Conditions For Departments are met:
    - The Department of Veterans Affairs (VA);
    - The Department of Defense (DOD); or

- The Department of Energy (DOE).

- The study of investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the clinical trial must be approved by the Health Benefit Plan as a Qualifying Clinical Trial.

Referred (Referral)

Electronic documentation from the Member's Primary Care Physician that authorizes Covered Services to be rendered by:

- A Participating Provider or group of Providers; or
- The Provider specifically named on the Referral.

Referred care includes all services provided by a Referred Specialist.

Referrals to Non-Participating Providers must be preapproved by the Health Benefit Plan.

A Referral:

- Must be issued to the Member prior to receiving Covered Services; and
- Is valid for 90 days from the date of issue for an enrolled Member.

For procedures for obtaining Preapproval for use of a Non- Participating Provider see Access To Primary, Specialist And Hospital Care in the ***General Information*** section.

Registered Dietitian (RD)

A dietitian registered by a nationally recognized professional association of dietitians.

- A Registered Dietitian (RD) is a food and nutrition expert who has met the minimum academic and professional requirements to qualify for the credential "RD."

Registered Nurse (R.N.)

A nurse who:

- Has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program); and
- Is licensed by the appropriate state authority.

Rehabilitation Hospital

A Facility Provider, approved by the Health Benefit Plan, which is primarily engaged in providing rehabilitation care services on an Inpatient basis.

- Rehabilitation care services consist of:
  - The combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability.
- Services are provided by or under:
  - The supervision of an organized staff of Physicians.
- Continuous nursing services are provided:
  - Under the supervision of a Registered Nurse.

Rehabilitation Therapy

Includes treatments designed to improve, maintain, and prevent the deterioration of skills and functioning for daily living that have been lost or impaired.

Reliable Evidence
Peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

Residential Treatment Facility
A Facility Provider licensed and approved by the appropriate government agency and approved by the Health Benefit Plan, which provides treatment for:
- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency to partial, Outpatient or live-in patients who do not require acute Medical Care.

Respite Care

Respite care is temporary care that relieves the family and/or caretaker(s) of a Member who is receiving Hospice care. Respite care generally takes place in a Skilled Nursing Facility (SNF).

Retail Clinics

Retail Clinics are staffed by certified nurse practitioners trained to diagnose, treat and write prescriptions when clinically appropriate.
- Services are available to treat basic medical needs for Urgent Care.
- Examples of needs are:
  - Sore throat;
  - Ear, eye or sinus infection;
  - Allergies;
  - Minor burns;
  - Skin infections or rashes; and
  - Pregnancy testing.

Rider
A legal document which modifies the protection of the Contract and this Benefit Booklet either by:
- Expanding, decreasing or defining benefits; or
- Adding or excluding certain conditions from coverage under the Contract and this Benefit Booklet.

Routine Patient Costs Associated With Qualifying Clinical Trials
Routine patient costs include all items and services consistent with the coverage provided under this Program that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do NOT include:
- The investigational item, device, or service itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Self-Administered Prescription Drug
A Prescription Drug that can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self-Administered Prescription Drugs include, but are not limited to:
- Oral drugs;
- Self-Injectable Drugs;
- Inhaled drugs; and
- Topical drugs.

Self-Injectable Prescription Drug (Self-Injectable Drug)
A Prescription Drug that:
- Is introduced into a muscle or under the skin by means of a syringe and needle; and
- Can be administered safely and effectively by the patient or caregiver without medical supervision, regardless of whether initial medical supervision and/or instruction is required.

Serious Mental Illness

Means any of the following biologically based Mental Illnesses: As defined by the American Psychiatric Association, in the most recent edition of the International Classification of Diseases (ICD) or Diagnostic and Statistic Manual of Mental Disorders (DSM):
- Schizophrenia;
- Bipolar disorder;
- Obsessive-compulsive disorder;
- Major depressive disorder;
- Panic disorder;
- Anorexia nervosa;
- Bulimia nervosa;
- Schizo-affective disorder
- Delusional disorder; and
- Any other Mental Illness that is considered to be “Serious Mental Illness” by law.

Benefits are provided for diagnosis and treatment of these conditions when:
- Determined to be Medically Necessary and
- Provided by a Behavioral Health/Alcohol or Drug Abuse and Dependency Provider.

Covered Services may be provided on an Outpatient or Inpatient basis.

Service Area

The geographical area within which the Health Benefit Plan is approved to provide access to Covered Services.

Severe Systemic Protein Allergy

Means allergic symptoms to ingested proteins of sufficient magnitude to cause:
- Weight loss or failure to gain weight;
- Skin rash;
- Respiratory symptoms; and
- Gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

Short Procedure Unit

A unit which is approved by the Health Benefit Plan and which is designed to handle the following kinds of procedures on an Outpatient basis:

- Lengthy diagnostic procedures; or
- Minor surgical procedures.

In the absence of a Short Procedure Unit these are procedures which would otherwise have resulted in an Inpatient Admission.

Skilled Nursing Facility

An institution or a distinct part of an institution, other than one which:

- Is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol Or Drug Abuse And Dependency;

It is also an institution which:

- Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- Is otherwise acceptable to the Health Benefit Plan.

Sleep Studies

Refers to the continuous and simultaneous monitoring and recording of various physiologic and pathophysiologic sleep parameters. Sleep tests are performed to:

- Diagnose sleep disorders (For example: narcolepsy, sleep apnea, parasomnias);
- Initiate treatment for a sleep disorder; and/or
- Evaluate an individual's response to therapies such as continuous positive airway pressure
- (CPAP) or bi-level positive airway pressure device (BPAP).

Sound Natural Teeth

Teeth that are:

- Stable;
- Functional;
- Free from decay and advanced periodontal disease;
- In good repair at the time of the Accidental Injury/trauma; and
- Are not man-made.

Specialist Services

All Professional Provider services providing Medical Care or mental health/Psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Care Dentist

A specialized Dentist who is:

- Board eligible;
- Board qualified; or
- Board certified in one of the following specialty areas:
  - Periodontics;
  - Oral surgery;
  - Orthodontics;
  - Endodontics;
  - Pediatrics; and

- Who has executed a contract with the Health Benefit Plan to accept negotiated fees plus any applicable Copayments, as payment in full for Covered Services provided to Members.

Specialty Drug
A medication that meets certain criteria including, but not limited to:
- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a healthcare provider to administer the drug.
- Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
- The drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.

The Health Benefit Plan reserves the right to determine which Specialty Drug vendors and/or healthcare providers can dispense or administer certain Specialty Drugs.

Standard Injectable Drug

A medication that is either injectable or infusible:
- But is not defined by the Health Benefit Plan to be a Self-Administered Prescription Drug or a Specialty Drug

Standard Injectable Drugs include, but are not limited to:
- Allergy injections and extractions; and
- Injectable medications such as antibiotics and steroid injections that are administered by a Participating Professional Provider.

Standing Referral (Standing Referred)

Electronic documentation from the Health Benefit Plan that authorizes Covered Services for: A life-threatening, degenerative or disabling disease or condition.
- The Covered Services will be rendered by the Referred Specialist named in the electronic documentation.
  - The Referred Specialist will have clinical expertise in treating the disease or condition.
- A Standing Referral must be issued to the Member prior to receiving Covered Services.
  - The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid.
  - Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

State Restricted Drug

A non-Federal Legend Drug which, according to State law, may not be dispensed without a Prescription Order or Refill.

Subscriber

The person who is eligible and is enrolled for coverage.

Surgery
The performance of generally accepted operative and cutting procedures including:
- Specialized instrumentations;
- Endoscopic examinations; and

- Other invasive procedures.

Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care.

Treatment of burns, fractures and dislocations are also considered Surgery.

Therapy Service (Rehabilitative and Habilitative Services)
The following services or supplies Prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Member:

- Cardiac Rehabilitation Therapy
  Medically supervised rehabilitation program designed to improve a Member's tolerance for physical activity or exercise.

- Chemotherapy
  The treatment of malignant disease by:
  – Chemical or biological antineoplastic (anti-cancer) agents;
  – Monoclonal antibodies (used to target and fight cancer cells);
  – Bone marrow stimulants (to help the bone marrow make new white blood cells);
  – Antiemetics (to prevent vomiting); and
  – Other related biotech products.

- Dialysis
  The treatment that removes waste materials from the body for people with:.
  – Acute renal failure; or
  – Chronic irreversible renal insufficiency.

- Infusion Therapy
  The infusion of:
  - Drug;
  - Hydration; or
  - Nutrition (parenteral or enteral);

  Into the body by a healthcare Provider.

  Infusion therapy includes: All professional services, supplies, and equipment that are required to safely and effectively administer the therapy.

  Infusion may be provided in a variety of settings (For example, home, office, Outpatient) depending on the level of skill required to:
  - Prepare the drug;
  - Administer the infusion; and
  - Monitor the Member.

  The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Health Benefit Plan.

- Occupational Therapy
  Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal (nerve, muscle and bone) functions which have been impaired by:

- Illness or injury;
- Congenital anomaly (a birth defect); or
- Prior therapeutic intervention.

Occupational Therapy also includes medically prescribed treatment concerned with improving the Member's ability to perform those tasks required for independent functioning, where such function has been permanently lost or reduced by:
- Illness or injury;
- Congenital anomaly (birth defect); or
- Prior therapeutic intervention (Prior treatment).

This does NOT include services specifically directed towards the improvement of vocational skills and social functioning.

- Physical Therapy
  Medically prescribed treatment of physical disabilities or impairments resulting from:
  - Disease;
  - Injury;
  - Congenital anomaly; or
  - Prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving:
    - Strength;
    - Mobility (or, Ambulation);
    - Endurance;
    - Balance
    - Coordination;
    - Joint mobility;
    - Flexibility; and
    - The functional activities of daily living.

- Pulmonary Rehabilitation Therapy
  A multidisciplinary, comprehensive program for Members who have a chronic lung disease.

  Pulmonary rehabilitation is designed to:
  - Reduce symptoms of disease;
  - Improve functional status; and
  - Stabilize or reverse manifestations of the disease.

  Multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

- Radiation Therapy
  The treatment of disease by any of the following, regardless of the method of delivery:
  - X-ray;
  - Gamma ray;
  - Accelerated particles;
  - Mesons;
  - Neutrons;
  - Radium or radioactive isotopes; or
  - Other radioactive substances.

- Respiratory Therapy
  Medically prescribed treatment of diseases or disorders of the respiratory system with

therapeutic gases and vaporized medications delivered by inhalation.

- Speech Therapy
  Medically prescribed services that are necessary for the diagnosis and/or treatment of speech disorders, language disorders, and cognitive communication impairments that result in communication disabilities or dysphasia (swallowing disorder) due to:
  - Disease;
  - Surgery;
  - Injury;
  - Congenital and developmental anomalies; or
  - Previous therapeutic processes.

Urgent Care

Urgent Care needs are for sudden illness or Accidental Injury that require prompt medical attention but are not life-threatening and are not Emergency medical conditions when the Member's Primary Care Physician is unavailable. Examples of Urgent Care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not Preventive Care or Follow-up Care.

Urgent Care Center

Participating Facility Provider's designed to offer immediate evaluation and treatment for sudden health conditions and accidental injuries that:
- Require medical attention in a non-emergency situation; and
- That cannot wait to be addressed by the Member's Primary Care Physician's office or Retail Clinic.

Urgent Care is not the same as: Emergency Services (see definition of Urgent Care above).

Use Of Provider Network (for Routine Patient Costs Associated with Qualifying Clinical Trials**)**
Benefits are payable when Qualifying Clinical Trials are conducted by a:
- Primary Care Physician;
- Non-Participating Specialist or (Participating Professional Provider); when:
  - Preapproved by the Health Benefit Plan; and
  - Conducted in a Participating Provider facility.

If there is no comparable Qualifying Clinical Trial being performed by, and in, Participating Providers, then:
- The Health Benefit Plan will consider the services by Non-Participating Providers as covered when approved by the Health Benefit Plan.

In the absence of meeting the Qualifying Clinical Trials criteria, the Clinical Trial must be approved by the Health Benefit Plan as a Qualifying Clinical Trial. See ***Access To Primary, Specialist, And Hospital Care*** for procedures for obtaining Preapproval for use of a Non-Participating Provider.

Use of Participating Providers

If one or more participating providers are participating in a clinical trial, nothing in the above paragraph shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

Use of Non-Participating Providers – Notwithstanding Use of Participating Providers as noted in paragraph above, paragraph one shall apply to a qualified individual participating in an approved clinical trial that is conducted outside the state in which the qualified individual resides.

IMPORTANT NOTICES

RIGHTS AND RESPONSIBILITIES

To obtain a list of Rights and Responsibilities, log onto http://www.ibx.com / /members/quality_management/member_rights.html, or the Member can call the Customer Service telephone number listed on their ID Card.

INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION[1]

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross[2] values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

Note: "Protected health information" or "PHI" is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

This revised Notice takes effect on September 23, 2013, and will remain in effect until we replace or modify it.

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[1] If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group's privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

[2] For purposes of this Notice, "Independence Blue Cross" refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclosure information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other IBC affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality

assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available IBC health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose "summary health information" to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor's group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct audits and investigations of the health care system, to determine eligibility for government programs, to

determine compliance with government program standards, and for certain civil rights enforcement actions.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers' compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a "designated record set." Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called "Your Privacy Rights Concerning Your Protected Health Information."

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed IBC Personal Representative Designation Form or documentation that supports the person's qualification according to state law (such as a power of attorney or guardianship). To request the IBC Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at *www.ibx.com*, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved IBC Authorization Form. To request the IBC Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at *www.ibx.com*, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)

You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved IBC form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross’s vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your

request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will **not** include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- before April 14, 2003.

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request, that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

Right to a Notification of a Breach of your PHI: You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Your Right to File a Privacy Complaint

If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross's privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your ID Card, or you may contact the Privacy Office as follows:

Independence Blue Cross
Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 - 1762

Fax: (215) 241-4023 or 1-888-678-7006 (toll free)
E-mail: Privacy@ibx.com
Phone: 215-241-4735 or 1-888-678-7005 (toll free)

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Independence