

KEYSTONE HEALTH BENEFITS PLAN

Administered by

Keystone Health Plan East, Inc.

("Keystone" or "the Claims Administrator")*

*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

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Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

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Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

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Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية, فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

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Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Dii baa akó ninizin: Dii saad bee yánilti'go Diné Bizaad, saad bee áká'anida'áwo'déé', t'áá jiik'eh. Hódiilnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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INTRODUCTION

Welcome to the Health Benefits Plan established by the Group and administered by Keystone Health Plan East, Inc..Keystone has entered into an arrangement with the Group to provide claims administration services and to make its Provider networks available for this Program.

This Benefit Booklet is a description of the terms, conditions and procedures required to be followed in order to receive the benefits and Covered Services to which the Member is entitled. Covered Services 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.

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 Administrative Services Only Agreement 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 Claims Administrator's procedures and services. **If Members have any questions, they should contact their Plan Administrator or 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 Administrative Services Only Agreement 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 Administrative Services Only Agreement 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 Group's anniversary date)
Program Deductible	
Per Member	\$500
Per Member and Dependents	\$1,000
Per Family	\$1,500
<p>The Family Deductible will be applied for all family Members covered under a family Coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Deductible for that Benefit Period, or the Family Deductible has been satisfied for all covered family Members combined.</p> <p>The Member will also be responsible to pay costs for services that are that are not covered by the Claims Administrator (SI).</p>	
Coinsurance	None
Out-of Pocket Maximum	
Per Member	\$4,500
Per Family	\$9,000
<p>The Out-of-Pocket Maximum is the maximum dollar amount that a Member pays for Covered Services in each Benefit Period. The Out-of-Pocket Maximum includes Copayments, Coinsurance, and Deductible amounts, if applicable, for Essential Health Benefits. 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.</p> <p>If you have met the Out-of-Pocket Maximum in this Benefit Period and your Provider continues to ask for cost sharing, please contact Customer Service.</p> <p>This maximum includes Copayments required under the Vision benefit, if made a part of the Program.</p>	
Lifetime Benefit Maximum	Unlimited

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 Claims Administrator 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 Claims Administrator'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](http://www.ibx.com/MyBenefitsInformation) 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
Acupuncture ⁽⁴⁾	\$25 Copayment per visit, Deductible does not apply
Note for Acupuncture shown above: Benefit Period maximum: 18 visits	
Alcohol or Drug Abuse And Dependency Treatment ⁽³⁾ (Including Detoxification Services)	
Inpatient Alcohol Or Drug Abuse And Dependency Treatment Admissions	None, after Deductible
Outpatient Alcohol Or Drug Abuse And Dependency Treatment Visits/Sessions	\$25 Copayment per visit/session, Deductible does not apply
Ambulance Services/Transport ⁽⁴⁾	
Emergency	None, Deductible does not apply
Non-Emergency	None, after Deductible

BENEFIT	COST-SHARING
Autism Spectrum Disorders⁽⁴⁾	Same cost-sharing as any other Covered Service within the applicable medical service category (For example, Specialist, Hospital Services, Therapy Services, etc.)
<p><i>Note for Autism Spectrum Disorders shown above:</i></p> <p>Annual Benefit Maximum for non-essential benefits: \$41,271</p> <p>Amounts accumulated to the Annual Benefit Maximum for Autism Spectrum Disorders are determined by all non-essential benefits paid for this condition. Copayments and/or Coinsurance paid by the Member are not added to the Annual Benefit Maximum.</p> <p>If this Program does not provide coverage for Prescription Drugs, Autism Spectrum Disorders medications are covered less the applicable Coinsurance per 30 day Prescription Order.</p> <p>Generic Coinsurance - 30% of the retail pharmacy price Brand Coinsurance - 30% of the retail pharmacy price</p>	
Blood⁽³⁾	None, after Deductible
Day Rehabilitation Program⁽⁴⁾	None, after Deductible
<p><i>Note for Day Rehabilitation Program shown above:</i> Benefit Period maximum: 30 visits</p>	
Diabetic Education Program⁽⁴⁾	None, Deductible does not apply
<p><i>Note for Diabetic Education Program shown above:</i> Copayments, Coinsurance and maximum amounts do not apply to this benefit</p>	
Diabetic Equipment And Supplies⁽⁴⁾	None, after Deductible
Diagnostic Services -Non-Routine⁽⁴⁾ (including MRI/MRA, CT scans, PET scans, Sleep Studies)	None, Deductible does not apply
Diagnostic Services – Routine⁽⁴⁾	None, Deductible does not apply
Diagnostic Mammogram	None, Deductible does not apply
Durable Medical Equipment and Consumable Medical Supplies⁽⁴⁾	None, after Deductible
Emergency Care Services⁽⁴⁾	\$35 Copayment (waived if admitted) , Deductible does not apply
<p><i>Note for the Emergency Services shown above:</i> The emergency room Copayment 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 Claims Administrator, and the services could have been provided in their Primary Care Physician's office.</p>	
Home Health Care⁽⁴⁾	None, after Deductible
<p><i>Note for Home Health Care shown above:</i> Unlimited Visits.</p>	

BENEFIT	COST-SHARING
Hospice Services⁽³⁾ Inpatient Hospice Service Outpatient Hospice Services Professional Service Facility Service for Respite Care	None, after Deductible None, after Deductible None, after Deductible None, after Deductible
<i>Note for Hospice Services shown above:</i> Respite Care: Maximum of seven (7) days every six (6) months.	
Hospital Services⁽²⁾	None, after Deductible
Immunizations⁽¹⁾	None, after Deductible
Injectable Medications⁽⁴⁾	None, Deductible does not apply
Insulin And Oral Agents⁽⁴⁾	None, less the Copayment amount, if applicable
<i>Note for Insulin and Oral Agents shown above:</i> If this Program does not provide coverage for Prescription Drugs, insulin and oral agents are covered less the applicable Copayment per Prescription Order: Generic Copayment – \$10 Brand Copayment – \$15	
Laboratory and Pathology Tests⁽⁴⁾	None, Deductible does not apply
Maternity/OB-GYN/Family Services⁽³⁾ Artificial Insemination Elective Abortions Professional Service Outpatient Facility Services Maternity/Obstetrical Care Professional Service Facility Service-Inpatient Birthing Center Newborn Care	None, Deductible does not apply \$25 Copayment per visit, Deductible does not apply \$25 Copayment per visit, Deductible does not apply None, after Deductible Single Copayment of \$25, Deductible does not apply None, after Deductible None, Deductible does not apply
Medical Care⁽²⁾	None, Deductible does not apply
Medical Foods and Nutritional Formulas⁽¹⁾	None, Deductible does not apply

BENEFIT	COST-SHARING
Mental Health Care and Serious Mental Illness Health Care⁽³⁾ Inpatient Admissions Outpatient Visits/Sessions	 None, after Deductible \$25 Copayment per visit/session, Deductible does not apply
Methadone Treatment	None, Deductible does not apply
Nutrition Counseling For Weight Management⁽¹⁾	None, Deductible does not apply
<i>Note for Nutrition Counseling For Weight Management shown above: Benefit Period Maximum: 6 counseling visits/sessions.</i>	
Preventive Care – Adult⁽¹⁾	None, Deductible does not apply
Preventive Care – Pediatric⁽¹⁾	None, Deductible does not apply
Primary Care Physician Office Visits/Retail Clinic - Non-Preventive⁽¹⁾ (Includes Home Visits and Outpatient Consultations)	\$10 Copayment per visit, Deductible does not apply
Private Duty Nursing Services⁽⁴⁾	None, Deductible does not apply
Prosthetic Devices⁽⁴⁾	None, after Deductible
Skilled Nursing Facility Services⁽²⁾	None, after Deductible
<i>Note for Skilled Nursing Facility Services shown above: Benefit Period maximum 180 days.</i>	
Smoking Cessation⁽¹⁾	None
Specialist Office Visits⁽⁴⁾	\$25 Copayment per visit, Deductible does not apply
Spinal Manipulation Services⁽⁴⁾	None, Deductible does not apply
<i>Note for Spinal Manipulation Services shown above: Medically Necessary treatment received in a 60 consecutive day period per acute medical episode. Treatment is limited to conditions which are subject to significant improvement within the treatment period.</i>	

BENEFIT	COST-SHARING
Surgical Services⁽³⁾	
Outpatient Facility Charge	None, after Deductible
Outpatient Anesthesia	None, after Deductible
Second Surgical Opinion (Voluntary)	\$25 Copayment per visit, Deductible does not apply
Therapy Services⁽⁴⁾	
Cardiac Rehabilitation Therapy	None, Deductible does not apply
Chemotherapy	None, after Deductible
Dialysis	None, after Deductible
Infusion Therapy	None, after Deductible
Orthoptic/Pleoptic Therapy	None, Deductible does not apply
<i>Note for Orthoptic/Pleoptic Therapy shown above: Lifetime Maximum: 8 sessions</i>	
Rehabilitation Therapy	None, Deductible does not apply
<p><i>Note for Rehabilitation Therapy shown above: Benefit Period maximum: 60 consecutive days per condition per acute medical episode.</i></p> <p>Treatment is limited to conditions which are subject to significant improvement within the rehabilitation benefit period.</p> <p>Benefit Period maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.</p>	
Pulmonary Rehabilitation Therapy	None, Deductible does not apply
Radiation Therapy	None, after Deductible
Respiratory Therapy	None, Deductible does not apply
Transplant Services⁽³⁾	None, after Deductible
Urgent Care Centers⁽⁴⁾	\$24 Copayment per visit, Deductible does not apply
Women's Preventive Care⁽¹⁾	None, Deductible does not apply
<p><i>Note for Women's Preventive Care shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained at a Participating Pharmacy or a Participating Mail Service Pharmacy for generic products and for certain brand products when a generic alternative or equivalent to the brand product does not exist.. All other Brand contraceptive products are covered at standard cost-sharing as reflected in this <i>Schedule of Covered Services</i>.</i></p>	

BENEFIT	FOR BENEFITS DISTRIBUTED BY NS412, LLC:
Naturally Slim® Foundations™(1) Distributed by NS412, LLC	None Deductible does not apply.
<i>Note for Naturally Slim® Foundations™ shown above: Benefit Period Maximum: 10 sessions</i>	

BENEFIT	FOR BENEFITS DISTRIBUTED BY NS412, LLC:
NS4You™(1) Distributed by NS412, LLC	None Deductible does not apply.
<i>Note for NS4You™ shown above: Benefit Period Maximum: 10 sessions</i>	

BENEFIT	FOR BENEFITS PROVIDED BY CONTRACTED VENDOR:
Telemedicine Services(4) Provided by Contracted Vendor	\$10 fee per Provider per date of service, Deductible does not apply

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.

Limited Pharmacy

(applies to coverage of Diabetes and Autism Spectrum Disorders only)

If this Program does not provide separate coverage for Prescription Drugs, benefits are provided for the following less the applicable cost share per Prescription Order.

Pharmacy Limitations:

1. This benefit does not include insulin and oral agents or ASD drugs available under a Prescription Drug benefit or a Freestanding Prescription Drug agreement under this plan.
2. A pharmacy need not dispense a Prescription Order which, in the Pharmacist's professional judgment, should not be filled, without first consulting with the prescribing physician.
3. The quantity of a Prescription Drug, for purposes of cost-sharing, dispensed from a pharmacy pursuant to a Prescription Order or Refill is limited to 30 days. That is, the Member will be responsible for the cost for each 30 day supply of insulin or oral agents or their ASD drug.
4. Prescription Refills will not be provided beyond six months from the most recent dispensing date.
5. The dollar amount paid by a third party, including but not limited to a drug manufacturer, will not accumulate toward any applicable Deductible or Out-of-Pocket Maximum to the extent permitted by law.
6. The Member will pay to the pharmacy one hundred percent (100%) of the cost for the insulin or oral agent dispensed or ASD drug. A claim for reimbursement should be submitted to the Claims Administrator. The Member can access a claim form at the Claims Administrator's website listed on their ID Card, or they can call Customer Service at the phone number listed on their ID Card to have one mailed to them.

- (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***

DESCRIPTION OF COVERED SERVICES

Subject to the Exclusions, conditions and Limitations of this program, the 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.

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 Claims Administrator. 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 Claims Administrator'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 for 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 Claims Administrator.
- 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 Claims Administrator 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 self-refer 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 Claims Administrator 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. A list of Preventive Care Covered Services can be found in the Preventive Schedule document. A complete listing of recommendations and guidelines can be found at <https://www.healthcare.gov/preventive-care-benefits/>.

The Claims Administrator reserves the right to modify the Preventive Schedule document at any time.

Allergy Injections

Benefits are provided for allergy extracts and allergy injections.

Hearing Screening for Diagnostic Purposes

Immunizations

The Claims Administrator 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 schedules may be found in the Preventive Schedule document.

Naturally Slim® Foundations™

The Claims Administrator will provide coverage for Naturally Slim® Foundations™ services distributed by NS412, LLC, up to the Benefit Period Maximum specified in the **Schedule of Covered Services**.

- The initial ten-week behavioral based nutritional intervention is designed to:
 - Educate Members on losing weight;
 - Increasing exercise; and
 - Making healthy lifestyle choices.
- NS412, LLC works with the Group to determine the enrollment criteria in the program based on:
 - Criteria developed and approved by NS412, LLC and the Group; and
 - Evaluation of the Member's risk for metabolic syndrome.
- Members will not be accepted into the program if the Member:
 - Is pregnant;
 - Indicates that they currently have or have had an eating disorder in the past;
 - Indicates they have a health condition that would make it unadvisable by a Professional Provider to go through the program; or
 - Indicates that they have a body mass index (BMI) of less than 19.

Eligible Dependents will not be able to enroll in the program.

NS4You™

The Claims Administrator will provide coverage for NS4You™ services distributed by NS412, LLC, up to the Benefit Period Maximum specified in the **Schedule of Covered Services**.

- The ten-week behavioral-based nutritional intervention program is designed to:
 - Reinforce the principles of the Naturally Slim® Foundations™ in those Members who have previously participated in the Foundations Program.
- NS412, LLC works with the Group to determine the enrollment criteria in the program based on:
 - Criteria developed and approved by NS412, LLC and the Group; and
 - Evaluation of the Member's risk for metabolic syndrome.
- Members will not be accepted into the program if the Member:
 - Is pregnant;

- Indicates that they currently have or have had an eating disorder in the past;
- Indicates they have a health condition that would make it unadvisable by a Professional Provider to go through the program; or
- Indicates that they have a body mass index (BMI) of less than 19.

Eligible Dependents will not be able to enroll in the program.

Nutrition Counseling for Weight Management

The Claims Administrator 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 Claims Administrator will provide coverage for Bone Mineral Density Testing (BMDT) in accordance with the Preventive Schedule document. 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 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 routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document attached to the Contract.

Preventive Care - Pediatric

Pediatric Preventive Care includes routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document attached to the Contract.

Primary Care Physician Office Visits/Retail Clinics

The Claims Administrator 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:

- | | |
|---|--|
| <ul style="list-style-type: none"> ▪ Sore throat; ▪ Ear, eye, or sinus infection; ▪ Allergies; | <ul style="list-style-type: none"> ▪ Minor burns; ▪ Skin infections or rashes; and ▪ Pregnancy testing. |
|---|--|

Smoking Cessation

Smoking cessation includes clinical preventive services rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) as described under the Preventive Services provision of the Patient Protection and Affordable Care Act.

Women's Preventive Care

Women's Preventive Care includes coverage for an initial physical examination for pregnant women to confirm pregnancy, screening for gestational diabetes, and other Covered Services, in accordance with the Preventive Schedule document.

Covered Services and Supplies include, but are not limited to, the following:

- Routine Gynecological Exam, Pap Smear. 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*.

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 mammograms without Referral. The Claims Administrator 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 when

provided by a Participating Provider.

- 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 when provided by a Participating Provider. Contraception drugs and devices are covered under this Program unless otherwise covered under the Prescription Drug benefit issued with this Program.

If a Member's Physician determines that they require more than one well-women visit annually to obtain all recommended preventive services (based on the women's health status, health needs and other risk factors), the additional visit(s) will be provided without cost-sharing.

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 Claims Administrator.

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 Claims Administrator.
- 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 Claims Administrator 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 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 self-refer is for Emergency Services.

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

PLEASE NOTE: ALL INPATIENT STAYS MUST BE PREAPPROVED BY THE CLAIMS ADMINISTRATOR AT LEAST FIVE WORKING DAYS BEFORE ADMISSION, EXCEPT FOR AN EMERGENCY ADMISSION.

Diabetic Equipment and Supplies

Benefits are provided for equipment and supplies which include:

- Glucose monitors;
- Monitor supplies;
- Insulin;
- Injection aids;
- Syringes;
- Insulin infusion devices;
- Pharmacological agents for controlling;
- blood Sugar; and
- Orthotics.

Hospital Services

Benefits are provided for unlimited days in a Hospital.

Rehabilitation Therapy Services may be subject to Limitations.

These limitations, if applicable, are shown on the ***Schedule of Covered Services***.

Unless otherwise included in this Benefit Booklet, the following inpatient Hospital services are Covered Hospital Services:

- Semi-private room and board (other accommodations if Medically Necessary);
- General nursing care;
- Prescription Drugs, medications, and biologicals; (the Claims Administrator reserves the right to apply quantity level limits as conveyed by the FDA or the Claims Administrator's Pharmacy and Therapeutics Committee for certain Prescription Drugs);
- Use of operating room and related services;
- Use of intensive care or cardiac units and related services;
- Oxygen services;
- Administration of whole blood and blood plasma;
- Other Medically Necessary supplies and equipment;
- Diagnostic Laboratory and X-ray.
- Anesthesia services when performed in connection with Covered Services; and
- Benefits are provided for Physician Care for Covered Services received during a Preapproved inpatient admission.

Prosthetic Devices

Surgically implanted Prosthetic Devices (except dental prostheses). For benefits related to Mastectomy Care, see Surgical Services.

Skilled Nursing Facility

The Claims Administrator will provide coverage for a Participating Skilled Nursing Care Facility:

- When Medically Necessary as determined by this Claims Administrator
- When the Member require treatment by skilled nursing personnel which can be provided:
 - Only on an Inpatient basis
 - Only in a Skilled Nursing Care 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 Claims Administrator'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 Claims Administrator 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.

Therapy Services

- Cardiac Rehabilitation Therapy

- Chemotherapy
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided if it meets all of the criteria listed below:
 - The Drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents.
 - The FDA- approved indication is based on reliable evidence demonstrating positive effect on health outcomes and/or the indication is supported by the established referenced Compendia identified in the Company's policies.
 - Drugs/biologics are eligible for coverage when they are injected or infused into the body by a Professional Provider.

Note: If this Program does not provide coverage for prescription drugs, oral antineoplastic agents are covered as provided under the benefits described above.

- Dialysis
Dialysis services are covered until the Member becomes eligible for Medicare coverage of Dialysis.

- Pulmonary Rehabilitation Services
Benefits are limited to treatment received during a covered inpatient admission.

- Radiation Therapy
Radiation Therapy services when provided during a covered inpatient admission.

- Rehabilitation Therapy Services
Inpatient rehabilitation therapy provided by a Hospital, a Skilled Nursing Facility, or a Rehabilitation Hospital. Covered therapies include: Occupational; Physical; Hand; Lymphedema; and Speech. Covered Services are subject to the determination that significant improvement can be expected and include:
 - All therapeutic exercise, testing and soft tissue mobilization;
 - All physical modalities utilizing heat, cold, light, air, electricity, sound, all forms of water therapy, massage, mobilization and mechanical stimulation;
 - Checking out the fitting of splints, braces, prostheses and other orthotic devices (orthotic devices are not covered unless stated otherwise); and
 - Reconditioning, including work reconditioning.

- Respiratory Therapy
Respiratory Therapy services when provided by a licensed respiratory therapist.

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 Claims Administrator.

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 Claims Administrator.
- 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 Claims Administrator.
- 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 Claims Administrator 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 self-refer is for Emergency Services.

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

PLEASE NOTE: ALL INPATIENT STAYS MUST BE PREAPPROVED BY THE CLAIMS ADMINISTRATOR AT LEAST FIVE WORKING DAYS BEFORE ADMISSION, EXCEPT FOR AN EMERGENCY ADMISSION.

Allergy Testing and Treatment

Allergy tests, testing materials, and treatment.

Blood

- Services related to an Outpatient transfusion:
 - These are services provided in conjunction with a planned episode of care that requires an Outpatient transfusion.
- Services related to an Inpatient transfusion:
 - These are Inpatient Services in conjunction with a planned episode of care that requires transfusion, including but not limited to, surgical procedures.
- Storage of autologous blood until the date of scheduled care.

Family Planning

Voluntary family planning services and infertility services. Covered Services include sterilization procedures, such as tubal ligation or vasectomy, and infertility diagnosis and counseling.

Hospice Services

The Claims Administrator will provide coverage for palliative and supportive services provided 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 Claims Administrator 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 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 Claims Administrator 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 Claims Administrator will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.

- Pre-notification -The Claims Administrator 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 Claims Administrator will provide coverage for:
 - 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 Claims Administrator will provide coverage for certain services provided by a Referred Specialist for elective home births.
- Scope of Care - The Claims Administrator 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.

This applies to the mother and her child, except as otherwise approved by the Claims Administrator.
- 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

Benefits are provided for Covered Services during:

- An Outpatient Mental Health Care or Serious Mental Illness Health Care visit/session.
 - Outpatient services include Tele-behavioral Health Services; or
- An Inpatient Mental Health Care or Serious Mental Illness Health Care admission.

Services are covered:

- For the treatment of a mental illness; and
- When provided by a Behavioral Health/Substance Abuse Provider.

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 your Primary Care Physician is not required to obtain Inpatient or Outpatient Mental Health Care or Serious Mental Illness Health Care. Instead:
 - Contact your Primary Care Physician; or
 - Call the telephone number shown on the back of your Member ID Card.

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

The criteria for Medical Necessity determinations made by the Participating Behavioral Health/Substance Abuse Provider with respect to Mental Health and Serious Mental Illness Health Care benefits will be made available to the Member upon request.

Routine Patient Costs Associated With Qualifying Clinical Trials

- The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

Surgical Services

The Claims Administrator 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 Claims Administrator will provide coverage for the following when performed after a mastectomy::
 - All stages of reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses and physical complications all stages of mastectomy, including lymphedemas; and
- 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" of this section.

- Routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

- Anesthesia

The Claims Administrator 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.

General Anesthesia, along with hospitalization and all related medical expenses normally incurred as a result of the administration of general Anesthesia, when rendered in conjunction with dental care provided to Members age seven (7) or under and for developmentally disabled Members when determined by the HMO to be Medically Necessary and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

- Assistant at Surgery

The Claims Administrator 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 Claims Administrator.

- Hospital Admission for Dental Procedures or Dental Surgery

The Claims Administrator 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 Claims Administrator 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.

To the extent that the Member has available dental coverage, the Claims Administrator reserves the right to seek recovery from the Provider.

The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Claims Administrator deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

▪ Second Surgical Opinion (Voluntary)

The Claims Administrator 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 Claims Administrator, as applicable, 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, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under 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 recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under the Benefit Booklet.
- When only the donor is a Member, the donor is entitled to the benefits of the Benefit Booklet for all related donor expenses, subject to following additional limitations:
 - The benefits are limited to only those benefits not provided or available to the donor from any other source of funding or coverage 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 Claims Administrator 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.
- Inpatient 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:

- 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.

The criteria for Medical Necessity determinations made by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider with respect to Treatment for Alcohol Or Drug Abuse And Dependency benefits will be made available to the Member upon request.

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 Claims Administrator.

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 Claims Administrator.
- 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 Claims Administrator 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 self-refer is for Emergency Services.

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

Acupuncture

The Health Benefit Plan will provide coverage for Acupuncture up to the limits specified in the ***Schedule of Covered Services*** for all Covered Services.

Ambulance Services/Transport

The Claims Administrator will provide coverage for Emergency ambulance services. However, these services need to be:

- Medically Necessary as determined by the Claims Administrator; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when 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 health or be inappropriate for 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.

In addition, the Health Benefit Plan will provide coverage for services provided by a licensed emergency services provider who initiates necessary intervention to evaluate and, if necessary, stabilize the condition of the Member and subsequently determines the Member does not require transport or the Member refuses to be transported. These services must be Medically Necessary as determined by the Health Benefit Plan.

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:
 - Non-emergency air or ground facility to facility transport may be covered when Medically Necessary as determined by the Claims Administrator (e.g. sending facility does not have the required services to effectively treat the Member, such as trauma or burn care).
 - Non-emergency air or ground transport may be covered to transport the Member back to a Participating Facility Provider in the Member's Service Area as determined by the Claims Administrator, when:
 - The transfer is Medically Necessary (as determined by the Claims Administrator's definition of Medical Necessity); and
 - The Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance.
 - Non-emergency ambulance transports are not provided for family members or companions, or for the convenience of the Member, the family, or the Provider treating the Member.

Autism Spectrum Disorders (ASD)

The Claims Administrator will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for the Members under 21 years of age when provided or Referred by the Primary Care Physician for the development of an ASD Treatment Plan. Benefits are subject to the ASD Annual Benefit Maximum listed in the Member's **Schedule of Covered Services**. All Medically Necessary care available for the treatment of ASD will be accrued against the ASD Annual Benefit Maximum. Treatment of Autism Spectrum Disorders must be:

- Prescribed, ordered or provided by a Participating Professional Provider, including the

Member's Primary Care Physician, Referred Specialist, licensed Physician Assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner;

- Provided by an Autism Service Provider, including a Behavior Specialist; or
- Provided by a person, entity or group that works under the direction of an Autism Service Provider.

Treatment of Autism Spectrum Disorders is defined as any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed Physician or licensed Psychologist who is a Participating Professional Provider:

- Applied Behavioral Analysis – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- Pharmacy Care - means the following when Prescribed and/or ordered by a licensed Physician, licensed Physician Assistant or Certified Registered Nurse practitioner who is a Participating Professional Provider:
 - Medications; and
 - Any assessment, evaluation or test to determine the need or effectiveness of such medications.

If this Program provides benefits for Outpatient Prescription Drugs through this Program or under a Freestanding Prescription Drug agreement issued by an affiliate of Keystone, the ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable under a Prescription Drug benefit.

If this Program does not provide coverage for Outpatient Prescription Drugs through this Program or under a Freestanding Prescription Drug agreement issued by an affiliate of Keystone, ASD medications may be purchased at a retail pharmacy, and are covered at the cost sharing stated in the Member's **Schedule of Covered Services** subject to the ASD Annual Benefit Maximum. In order to receive reimbursement, the Member must submit a completed claim form to the address listed on the form. The Member can access a claim form at the Claims Administrator website or the Member can call Customer Service at the phone number listed on the ID Card to have one mailed to them.

- Psychiatric Care – Direct or consultative services provided by a Physician specializing in psychiatry who is a Participating Professional Provider.
- Psychological Care – Direct or consultative services provided by a Psychologist who is a Participating Professional Provider.
- Rehabilitative Care – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- Therapeutic Care – Services provided by a speech language pathologist, occupational therapist or Physical Therapist who is a Participating Professional Provider.

An ASD Treatment Plan shall be developed by a licensed Physician or licensed Psychologist who is a Participating Professional Provider pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The ASD Treatment Plan may be

reviewed by the Claims Administrator once every six months. A more or less frequent review can be agreed upon by the Claims Administrator and the licensed physician or licensed Psychologist developing the ASD Treatment Plan.

A diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a Participating Professional Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than 12 months, unless a licensed physician or licensed Psychologist determines an earlier assessment is necessary.

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a Member shall be entitled to file an appeal. The appeal process will:

- Provide internal review followed by independent external review; and,
- Have levels, expedited and standard appeal time frames, and other terms established by the Claims Administrator consistent with applicable Pennsylvania and federal law.

Appeal filing procedures will be described in notices denying any Autism Spectrum Disorders benefits. Full appeal process descriptions will be provided after a new appeal is initiated and can also be obtained at any time by contacting Customer Service.

Colorectal Cancer Screening

The Claims Administrator will provide coverage for colorectal cancer screening for Symptomatic Members, Nonsymptomatic Members over age 50, and Nonsymptomatic Members under age 50 who are at high risk or increased risk for colorectal cancer. Coverage for colorectal cancer screening must be in accordance with the current American Cancer Society guidelines, and consistent with approved medical standards and practices. Benefits are provided for the following Covered Services:

- Coverage for Symptomatic Members shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests when provided by a Primary Care Physician or Referred Specialist
- Coverage for Nonsymptomatic Members over age 50 shall include:
 - An annual fecal occult blood test;
 - A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years; and
 - A colonoscopy at least once every ten years.
- Coverage for Nonsymptomatic Members under age 50 who are at high or increased risk for colorectal cancer shall include a colonoscopy or any combination of colorectal cancer screening tests.

"Nonsymptomatic Member at high or increased risk" means a Member who poses a higher than average risk for colorectal cancer according to the current American Cancer Society guidelines on screening for colorectal cancer.

"Symptomatic Member" means a Member who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

Consumable Medical Supplies

The Claims Administrator will provide coverage for the purchase of Consumable Medical Supplies when:

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

Day Rehabilitation Program

The Claims Administrator will provide coverage for a Medically Necessary Day Rehabilitation Program when provided by a Participating Facility Provider under the following conditions:

- Intensity of need for therapy: The Member must require intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five days per week;
- Ability to communicate: The Member must have the ability to communicate (verbally or non-verbally); their needs; they must also have the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff;
- Willingness to participate: The Member must be willing to participate in a Day Rehabilitation Program; and
- Family support: The Member's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

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

Diabetic Education Program

Benefits are provided for self-management training and education relating to diet when prescribed by a Primary Care Physician or Referred Specialist. Covered Services may be provided by a Participating Provider who is a licensed health care professional approved by the Claims Administrator. A Referral from the Member's Primary Care Physician is not required to obtain services for the Diabetic Education Program benefits.

Covered Services may also be provided by a participating community-based program which is approved by the Claims Administrator in accordance with criteria based on the certification programs for diabetic self-management training and education programs developed by the American Diabetes Association and the Pennsylvania Department of Health, or at a Participating Hospital on an outpatient basis as follows:

- Visits Medically Necessary upon the diagnosis of diabetes;
- Visits under circumstances whereby your Primary Care Physician or Referred Specialist identifies or diagnoses a significant change in your symptoms or condition that necessitates changes in your self-management; and
- Where a new medication or therapeutic process relating to your treatment and/or management of diabetes has been identified as Medically Necessary by your Primary Care Physician.

Diabetic Equipment and Supplies

- Coverage and costs: The Claims Administrator 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 diabetic equipment and supplies can be purchased at a pharmacy:

- If this Program provides benefits for Prescription Drugs (other than coverage for insulin and oral agents only):
 - 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 diabetic equipment and supplies are not available at a pharmacy:

- The diabetic equipment and supplies 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.

* **Note:** If this Program does not provide coverage for Prescription Drugs, insulin and oral agents are covered as provided under the "Insulin and Oral Agents" benefits.

Diagnostic Services

The Claims Administrator 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, such as:
 - Routine radiology: Consisting of x-rays, mammograms, ultrasound, and nuclear medicine;
 - Routine medical procedures: Consisting of ECG, EEG and other diagnostic medical procedures approved by the Claims Administrator; and
 - Allergy testing: Consisting of percutaneous, intracutaneous and patch tests.
- Non-Routine Diagnostic Services, such as:
 - Nuclear Cardiology Imaging;
 - Operative and diagnostic endoscopies;
 - MRI/MRA;
 - CT Scans;
 - PET Scans; and
 - Sleep Studies.
- 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 Claims Administrator, these services are covered for the purpose of:

- Diagnosis;
- Predicting the course of a disease;
- Judging the response to a therapy;
- Screening;
- Examining risk for a disease; or
- Reproductive decision-making.

The above Covered Services must be performed by the Member's Primary Care Physician's Designated Provider, except as follows:

- Diagnostic outpatient radiology services for Members less than age 5 may be performed by any Participating Provider that is contracted by the Claims Administrator to perform radiology services.

Durable Medical Equipment

The Claims Administrator will provide coverage for the rental (but not to exceed the total allowance) or, at the option of the Claims Administrator, 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

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 Claims Administrator in the case of rented equipment; and
- The Member, in the case of purchased equipment.

Breakage during reasonable useful lifetime: The Claims Administrator 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 Claims Administrator will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

Cost to repair vs. cost to replace: The Claims Administrator 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.

Hearing Care

Benefits are provided for hearing screenings performed for diagnostic purposes.

Home Health Care

- Covered Services: The Claims Administrator 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
 - Home health aides in conjunction with skilled services and other services which may be approved by the Claims Administrator.
- 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 Claims Administrator 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.

Injectable Medications

The Claims Administrator 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.

To obtain a list of Specialty Drugs please logon to www.ibx.com or call the Customer Service telephone number shown on the Member's ID Card.

Preapproval is required for those Specialty Drugs noted in the Preapproval list.

- Standard Injectable Drugs
 - Refers 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 Participating Professional Provider.
- Self-Administered Prescription Drugs
 - Are generally not covered except as covered under a Prescription Drug benefit.
 - For more information on Self-Administered Prescription Drugs please refer to the ***Exclusions – What Is Not Covered*** section and the description of "Insulin and Oral Agents" coverage in the ***Description of Covered Services*** section.

Insulin and Oral Agents

The Claims Administrator will provide coverage for Insulin and oral agents to control blood sugar when Prescribed by the Member's Primary Care Physician or Referred Specialist. Generically equivalent pharmaceuticals will be dispensed whenever applicable.

Laboratory and Pathology Tests

Medical Foods and Nutritional Formulas

- The Claims Administrator 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 Claims Administrator will provide coverage for Nutritional Formulas when the Nutritional Formula is taken orally or through a tube by an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.
- The Claims Administrator will provide coverage for Medical Foods and Nutritional Formulas when provided through a Participating 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 those with IEMs, or for when administered through a tube.

Methadone Treatment

- Provision and supervision of methadone hydrochloride in prescribed doses for the treatment of opioid dependency.

Non-Surgical Dental Services

The Claims Administrator 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 Claims Administrator 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 Claims Administrator. 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.

Podiatric Care

The Claims Administrator will provide coverage for:

- Capsular or surgical treatment of bunions
- Ingrown toenail Surgery; and
- Other non-routine Medically Necessary foot care.

In addition, for Members with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, routine foot care services are covered.

Private Duty Nursing Services

Benefits will be provided as specified in the ***Schedule of Covered Services*** for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician. All nursing services must be Medically Necessary as determined by the Claims Administrator.

Prosthetic Devices

The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator will neither replace nor repair the Prosthetic Device due to abuse or loss of the item.

Specialist Office Visit

The Claims Administrator 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 Claims Administrator 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).

- Covered Services may be provided by the Member’s Primary Care Physician or Referred Specialist licensed to perform such services.
- Spinal manipulation Covered Services are provided in order to treat an acute condition related to an acute medical episode.
- They are subject to the determination that significant improvement can be expected

This service will be provided for, up to the limits specified in the ***Schedule of Covered Services*** for spinal manipulations

Telemedicine Services

Services Provided by Contracted Vendor:

Telemedicine services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone or secure video when a Primary Care Physician is unavailable or inaccessible. These licensed providers do not replace an existing Primary Care Physician relationship but enhances it with an efficient, cost-effective alternative for non-emergency medical problems. The applicable vendor provider cost-sharing requirements are specified in the Schedule of Covered Services. The Member will pay the applicable cost-sharing via credit or debit card prior to the consultation.

Benefits Provided by Professional Provider:

Telemedicine services are also covered, when provided by a Participating Professional Provider and subject to the relevant cost share applicable to that provider. The provider’s eligibility will be determined by the Health Benefits plan in the Claims Administrator’s Medical Policies, who is licensed in the state where the telemedicine service is being offered. Telemedicine services are covered when the encounter takes place via a secure Health Insurance Portability and

Accountability Act (HIPAA)- compliant interactive audio and video telecommunications system as specified in the Claims Administrator's Medical Policies.

Therapy Services

- Cardiac Rehabilitation Therapy

- Chemotherapy

The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided if it meets all of the criteria listed below:

- The drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents.
- The FDA- approved indication is based on reliable evidence demonstrating positive effect on health outcomes and/or the indication is supported by the established referenced Compendia identified in the Company's policies.
- Drugs/biologics are eligible for coverage when they are injected or infused into the body by a Professional Provider.

Note: If this Program does not provide coverage for prescription drugs, oral antineoplastic agents are covered as provided under the benefits described above.

- 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 Claims Administrator. The Covered Services performed in a Participating Facility Provider or by a Participating Provider for Dialysis are available without a Referral.

- Infusion Therapy

Treatment including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration 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 Claims Administrator.

- Pulmonary Rehabilitation Service

Benefits are limited to treatment received within a 60 consecutive day period.

- Radiation Therapy

- Rehabilitation Therapy Services

Covered Services for all covered therapies other than Hand and Speech Therapies must be performed by the Member's Primary Care Physician's Designated Provider. Covered Services for acute conditions are subject to the determination that significant improvement can be expected within sixty (60) days.

Covered therapies include:

- Hand;
- Lymphedema;
- Occupational;
- Orthoptic/pleoptic;
- Physical; or
- Speech.

Covered Services include:

- All therapeutic exercise, testing and soft tissue mobilization;
- All physical modalities utilizing heat, cold, light, air, electricity, sound, all forms of water therapy, massage, mobilization and mechanical stimulation;
- Checking out the fitting of splints, braces, prostheses and other orthotic devices (orthotic devices are not covered unless stated otherwise);
- Reconditioning, including work reconditioning; and
- Orthoptic/pleoptic therapy, provided by a licensed ophthalmologist or optometrist.

Limitations, if applicable, are shown on the ***Schedule Of Covered Services***.

▪ Respiratory Therapy

Respiratory Therapy services when provided by a licensed respiratory therapist.

Urgent Care Centers

The Claims Administrator will provide coverage for Urgent Care Centers, when Medically Necessary as determined by the Claims Administrator.

- 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 (Medical)

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

Vision Examination

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

The Specialist Office Visit Copay as shown on the ***Schedule of Covered Services*** applies.

- 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, and/or oversized lenses.

Benefits are provided for prescription contact lenses in lieu of eyeglasses for up to \$35 every two calendar years.

Reimbursement For Prescription Lenses And Frames From A Non-Participating Provider

Each Member is entitled to a reimbursement for the cost of corrective lenses, including prescription contact lenses, and eyeglass frames. The reimbursement amount is stated below

and will be paid when a properly receipted bill is submitted. Instructions for reimbursement may be obtained from Customer Service.

Reimbursement Amount: \$35 every two calendar years.

A Member who receives Vision services from a Participating Provider can elect to utilize a Non-Participating Provider for related Vision services on the recommendation or referral of the Participating Provider, provided that the Participating Provider gives to the Member, prior to recommending, referring, Prescribing or ordering any Vision services from the Non-Participating Provider, written notice that:

- The Non-Participating Provider is not a Participating Provider;
- The Member has the option of selecting a Participating Provider; and
- The Member may have different financial obligations depending on whether the Vision Provider is a Participating Provider or a Non-Participating Provider.

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 a Referred Specialist.

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.

Note: For Emergency Care provided by certain Non-Participating Providers, for example, ambulance services, in accordance with applicable law, the Claims Administrator will reimburse the Non-Participating Provider at an in-network rate directly. In this instance the specified Non-Participating Provider will not bill the Member for amounts in excess of the Claims Administrator’s payment for the Emergency Care. Payment for Emergency Services provided by Non-Participating Providers will be the greater of:

- The median of the amounts paid to Participating Providers for Emergency Services;

- The amount paid to Non-Participating Providers; or
- The amount paid by Medicare.

It is the Member's responsibility to contact the Claims Administrator 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 Claims Administrator about these bills, the Claims Administrator will resolve the balance billing.

MEDICAL SCREENING EVALUATION

Medical Screening Evaluation services will be Covered Services when performed in a Hospital emergency department for the purpose 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 require prompt medical attention, but are not life-threatening and are not Emergency medical conditions, when your 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 your 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 Claims Administrator'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 Claims Administrator'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).

Urgent Care required during a temporary absence will be covered when:

- The Member calls 1-800-810-BLUE (TTY: 711). 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 (TTY: 711) to get prior authorization for the service from the 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 (TTY: 711) 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 (TTY: 711).
- 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.

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 69353
Harrisburg, PA 17106-9353.**

NOTE: 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 Claims Administrator 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 Claims Administrator.

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 Claims Administrator 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 Claims Administrator.

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:

- 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/Transport

For Ambulance services/transport 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.

Autism

- For Autism Spectrum Disorders services that exceed the Annual Benefit Maximum shown in the ***Schedule of Covered Services***.
- For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
- For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

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.

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).

Consumable Medical Supplies

With regard to Consumable Medical Supplies, any item that meets the following criteria is not a covered consumable medical supply and will not be covered:

- The item is for comfort or convenience.
- The item is not primarily medical in nature. Items not covered include, but are not limited to: ear plugs; ice pack; silverware/utensils; feeding chairs; toilet seats
- The item has features of a medical nature which are not required by the patient's condition.
- The item is generally not prescribed by an eligible provider.

Some examples of not covered consumable medical supplies are: incontinence pads; lamb's wool pads; face masks (surgical); disposable gloves, sheets and bags, bandages, antiseptics, and skin preparations.

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.

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).

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. Prescription Drugs used in the treatment of Autism Spectrum Disorders, when the Member does not have coverage through a Prescription Drug benefit.

Durable Medical Equipment

With respect to Durable Medical Equipment (DME), items 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.
- 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:
 - Exercise equipment;
 - Speech teaching machines;
 - Strollers;
 - Toileting systems;
 - 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 Claims Administrator 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 Claims Administrator.

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 Routine Foot Care, as defined in the HMO's medical policy unless associated with Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes.

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 and the fitting thereof; and, routine hearing examinations. Services and supplies related to these items are not covered. Cochlear electromagnetic hearing devices, a semi-implantable hearing aid, is not covered. Cochlear electromagnetic hearing devices are not considered cochlear implants.

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 Claims Administrator.

Home Blood Pressure Machines

For Home blood pressure machines, except for Members:

- With pregnancy-induced hypertension;
- With hypertension complicated by pregnancy;
- With end-stage renal disease receiving Home dialysis; or
- Who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates.

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.

Medical Foods And Nutritional Formulas

- For appetite suppressants; and
- For oral non-elemental nutritional supplements (For example, Boost, Ensure, NeoSure, PediaSure, Scandishake), casein hydrolyzed formulas (For example, Nutramigen, Alimentun, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, soy-based products. 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***.
- For elemental semi-solid foods (e.g. Neocate Nutra)
- For products that replace fluids and electrolytes (e.g., Electrolyte Gastro, Pedialyte)
- For oral additives (e.g., Duocal, fiber, probiotics, or vitamins) and food thickeners (e.g., Thick-It, Resource ThickenUp)
- For supplies associated with the oral administration of formula (e.g., bottles, nipples)

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 Claims Administrator, 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 Claims Administrator and described in this Benefit Booklet.

Mental Illness and Alcohol Or Drug Abuse And Dependency

- 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

- 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 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".
- For any Therapy service provided for:
 - Work hardening activities/programs;
 - Evaluations not associated with therapy.

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 Claims Administrator 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.

Obesity

For treatment of obesity including, but not limited to: (a) weight management programs; (b) dietary aids, supplements, injections and medications; (c) weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician; (d) group nutrition counseling.

This exclusion does not apply to:

- Surgical procedures specifically intended to result in weight loss (including bariatric surgery) when Claims Administrator:
 - Determines the Surgery is Medically Necessary; and
 - The Surgery is limited to one surgical procedure per lifetime, regardless (or even) if:
 - a new or different diagnosis is the indication for the Surgery
 - a new or different type of Surgery is intended or performed
 - a revision, repeat, or reversal of any previous weight loss Surgery is intended or performed.
 - The exclusion of coverage for a repeat, reversal or revision of a previous Surgery does not apply when the intended procedure is performed to treat technical failure or complications of a prior surgical procedure which, if left untreated, would result in endangering the health of the Member. Failure to maintain weight loss or any condition resulting from or associated with obesity does not constitute technical failure.
- 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.

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 (Medical Program)

- For Prescription Drugs, except as may be provided under the "Prescription Drugs" section of the Description of Covered Services. This exclusion does NOT apply to contraceptives as mandated by the Women's Preventive Services provision of the Patient Protection and Affordability Act, 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 Private Duty Nursing Services in connection with the following:
 - Nursing care which is primarily custodial in nature; such as care that primarily consists of bathing, feeding, exercising, homemaking, moving the patient and giving oral medication;
 - Services provided by a nurse who ordinarily resides in the Member's Home or is a member of the Member's Immediate Family; and
 - Services provided by a home health aide or a nurse's aide.
- For Inpatient 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 Services**.

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

Claims paid or payable by Medicare when Medicare is primary. For purposes of this Program exclusion, coverage is not available for a service, supply or charge that 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. The amount excluded for these claims will be either the amount “payable under Medicare” or the applicable plan fee schedule for the service, at the discretion of the Health Benefit Plan or Claims Administrator, as applicable.

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:

- 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 Claims Administrator 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 and services for Autism Spectrum Disorders);
- 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 Claims Administrator.

Services with No Charge

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

Sexual Dysfunction

Sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist.

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;
- Treatment or care to effect environmental or social change; or
- Autism Spectrum Disorder.

Except as otherwise provided in this program.

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 Claims Administrator'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 androgenetic alopecia 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 THE 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 Claims Administrator of such eligibility. The Claims Administrator 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 Claims Administrator of the eligibility status of a particular Member, the Claims Administrator will provide and terminate coverage in accordance with any Claims Administrator administrative processes.

ELIGIBILITY

Eligible Subscriber

An eligible Subscriber is an individual who is listed on the completed Enrollment/Change Form provided by the Claims Administrator and:

- Who resides or, with approval from the Claims Administrator, 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.

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, 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 or Domestic Partner is a court appointed legal guardian; or
- A child, regardless of age, who, in the judgment of the Claims Administrator, 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 Claims Administrator; 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 Claims Administrator approved by the Department of Military & Veterans Affairs (DMVA):

- Notifying the Claims Administrator that the Dependent has been placed on active duty;
 - notifying the Claims Administrator 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 Claims Administrator; 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 Claims Administrator.

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.

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 Claims Administrator; 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 Claims Administrator; 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 Claims Administrator.

If on the date on which coverage under the Claims Administrator 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 Claims Administrator effectively administer Members' health care benefits, the Claims Administrator must receive notice from the Benefits Administrator 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 Claims Administrator 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 Claims Administrator receives notification and a copy of the court order.

REMEMBER: The Member must notify the Claims Administrator 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 Claims Administrator should be through the benefits office of their Group benefits administrator.

TERMINATION OF COVERAGE

A Member's coverage may be cancelled, after receiving thirty (30) days advance written notice before cancellation and subject to their rights under the ***Complaint and Grievance Appeal Process***, under the following conditions:

- **Rescission:** If the Member commits intentional misrepresentation of a material fact or fraud in applying for or obtaining coverage from this Program. The Member will receive written notice at least thirty (30) days prior to termination but will have the right to utilize the ***Complaint and Grievance Appeal Process*** to appeal cancellation;
- **Misuse of ID Card:** 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;
- **Changes to Eligibility:** If a Member ceases to meet the eligibility requirements;
- **Group Termination:** The Member's Group terminates coverage with 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 Claims Administrator, 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 Claims Administrator that Inpatient Care is no longer Medically Necessary; or
- The Member's discharge from the facility.

NOTE: The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 them 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 their 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 they are 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 Claims Administrator, 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 Claims Administrator 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 Claims Administrator 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 their loss of dependent eligibility as defined in this Program, other than the Subscriber's coverage ending, they 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 Continued Ends" paragraph of this subsection.
- Election of Continuation: To continue their group health benefits, the qualified beneficiary must give the Benefits Administrator written notice that they elect to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of their 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 Claims Administrator 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 Claims Administrator.

- **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 they become 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 they satisfy 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 CLAIMS ADMINISTRATOR'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER MINI-COBRA ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION.

THE CLAIMS ADMINISTRATOR 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 the coverage in an appropriate non-group program. The Member must reside in the 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 the 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 Claims Administrator 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 Claims Administrator.

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 the 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 Claims Administrator for cause (such as deliberate misuse of an ID Card, significant misrepresentation of information that is given to the Claims Administrator 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 Keystone Health Plan East, Inc. ('Keystone' or 'the Health Benefit Plan') make the following information available to the Member when they make a request in writing to the Claims Administrator.

- A list of the names, business addresses and official positions of the membership of the Board of Directors or Officers of the Claims Administrator.
- 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 Claims Administrator to make decisions about the experimental nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by the Claims Administrator to reimburse for health care services. (This does not mean that the Claims Administrator 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 Claims Administrator's quality assurance program.

Confidentiality And Disclosure Of Medical Information

The Claims Administrator's privacy practices, as they apply to Members enrolled in this health benefit program, as well as a description of Member s' rights to access their personal health information which may be maintained by the Claims Administrator, are set forth in the Claims Administrator's HIPAA Notice of Privacy Practices (the "Notice"). The Notice is sent to each new Member upon initial enrollment in this Claims Administrator, and, subsequently, to all Member s if and when the Notice is revised.

By enrolling in this Claims Administrator, Members give consent to the Claims Administrator 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 Claims Administrator'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 Claims Administrator when required. A Standing Referral may be available to the Member if they have a life-threatening, degenerative or disabling disease or condition.

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 their 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 their 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 Claims Administrator.** The Member's Primary Care Physician or Referred Specialist works with the Claims Administrator'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***. Instructions for the appeal will be described in the denial notifications.
- **All services must be received from Participating Providers** unless Preapproved by the Claims Administrator, 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 Specialist, 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 Claims Administrator.** 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 Claims Administrator 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 Claims Administrator researches all scientific information available from these expert sources. Following this analysis, the Claims Administrator 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. A Member or their Provider should contact the Claims Administrator to determine whether a proposed treatment is considered "emerging technology" and whether the provider is considered an eligible provider to perform the "emerging technology" Covered Service. The Claims Administrator maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

- **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, if the Member does not have Prescription Drug coverage under a Claims Administrator Prescription Drug benefit, this Program will provide coverage for insulin and oral agents, as well as Prescription Drugs used in the treatment of Autism Spectrum Disorders, when the Member is not an Inpatient.

Groups may choose to provide additional Prescription Drug coverage for Prescription Drugs for use when a Member is not an Inpatient. The benefits and cost sharing will vary depending upon the program chosen. That coverage may also include a Drug Formulary. If so, the Member will be given a copy of the Drug Formulary, and the coverage may exclude, or require the Member to pay higher Copayments for certain Prescription Drugs. To obtain a copy of the Drug Formulary, the Member should call Customer Service at the phone number shown on their ID Card.

Prescription Drug benefits do not cover over-the-counter drugs except insulin.

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

The Claims Administrator, for all Prescription Drug benefits, requires prior authorization of a small number of drugs approved by the FDA for use in specific medical conditions. Where prior authorization 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 the Member's 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator that they decline participation; or
- The Claims Administrator 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 Claims Administrator 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 Claims Administrator determines in its discretion that the Member is entitled to them.

Out-Of-Area Services

Overview

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"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). 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 Arrangements.

When the Member receives care outside of Keystone's Service Area, they will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield in that geographic area ("Host Blue"). Some providers ("non-participating providers") don't contract with the Host Blue. Keystone explains below how we pay both kinds of providers.

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 Arrangements, unless authorized by the Member's Primary Care Physician ("PCP").

A. 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 doing what we agreed to in the contract. 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 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***.

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.

When the Member receives Out-of-Area Covered Healthcare Services outside Keystone's Service Area and the claim is processed through the BlueCard Program, the amount the Member pays for the Out-of-Area 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 pays to 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 also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price Keystone has used for the Member's claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Keystone will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

B. Non-Participating Healthcare Providers Outside Keystone's Service Area

Your Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of Keystone's Service Area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Keystone will make for the Out-of-Area Covered Healthcare Services as set forth in the Group Contract. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions

In certain situations, Keystone may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment to determine the amount Keystone will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment Keystone will make for the Out-of-Area Covered Healthcare Services as set forth in the Group Contract.

C. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

▪ Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Keystone to obtain precertification for non-emergency inpatient services.**

▪ Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

ACCESS TO PRIMARY, SPECIALIST, AND HOSPITAL CARE

Direct Access To Certain Care

A Member does not need a Referral from their 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 Claims Administrator 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.

If the Standing Referral is Approved

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 Claims Administrator 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.

If the Standing Referral is Denied

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

If a Member wishes to transfer to a different Primary Care Physician, a request can be made at any time, by:

- submitting in writing, calling the telephone number shown on the back of the Member ID Card, or using the IBX Mobile app to the HMO's Customer Service Department, or
- logging into the website at www.ibxpress.com and selecting Account Settings and Member Information.

The change will become effective on the earlier of:

- 14 days after the request is received (includes weekends), or
- the first day of the upcoming month.

Exceptions: However, changes will take effect on the first of the current month:

- when the Member did not make a PCP selection at the time of enrollment, or
- if the Member's PCP is no longer a Participating Provider.

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

The Member must remember to have their medical records transferred to their new 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 visit 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 Claims Administrator, 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 Claims Administrator terminates its contract with that Physician, for reasons other than cause; or
- The Member first enrolls in the 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator prior to receiving care. The Claims Administrator reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.

If the Claims Administrator 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 Claims Administrator'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 Claims Administrator about these bills, the Claims Administrator 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 Claims Administrator, and the Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator's network, and to be informed by their Physician of the medical consequences of their refusal of any drugs, treatment, or procedure.

The Claims Administrator 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 Claims Administrator 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 Claims Administrator, the Claims Administrator 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 Claims Administrator shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Claims Administrator shall provide access to Covered Services in so far as practical, and according to its best judgment. Neither the Claims Administrator nor Providers in the Claims Administrator'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 Claims Administrator and appropriate regulatory authority, are extraordinary circumstances not within the control of the Claims Administrator, 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 Claims Administrator should provide coverage for any contractually excluded services through inadvertence or error, the Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Specialist: Most Referred Specialist are paid on a fee-for-service basis, meaning that payment is made according to the Claims Administrator'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 Claims Administrator's 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 Claims Administrator'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 Claims Administrator about these bills, the Claims Administrator 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.

Integrated Delivery Systems: In a few instances, we have global payment arrangements with integrated Hospital/Physician organizations called Integrated Delivery Systems (IDS). In these cases the IDS provides or arranges for some of the Hospital, Physician and ancillary Covered Services provided to some of our Members who select PCPs which are employed by or

participate with the IDS. The IDS is paid a global fee to cover all such Covered Services, whether provided by the IDS or other Providers. These IDSs are therefore “at risk” for the cost of these Covered Services. Some of these IDSs may provide incentives to their IDS-affiliated Professional Providers for meeting certain quality, service or other performance standards.

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. In Pennsylvania, we have entered into a joint venture with an IPA. This IPA is paid a global fee to cover the cost of all Covered Services, including Hospital, professional and ancillary Covered Services provided to Members who choose a PCP in this IPA. This IPA is therefore “at risk” for the cost of these Covered Services. This IPA provides incentives to its affiliated Physicians for meeting certain quality, service and 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 Claims Administrator 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 Behavioral 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.

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 Claims Administrator in making coverage determinations for certain requested health care services, the Claims Administrator uses established Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator'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 Claims Administrator'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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator'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 Claims Administrator 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 Claims Administrator reserves the right to waive medical review for certain Covered Services for certain Providers, if the Claims Administrator 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 Claims Administrator'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 Claims Administrator 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 Claims Administrator'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 Claims Administrator's determinations for similar medical issues and requests, and reduce practice variation among the Claims Administrator'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; 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 Claims Administrator's Medical Policies

These are the Claims Administrator's internally developed set of policies which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

The Claims Administrator's medical policies may be applied for Covered Services including, but not limited to the following:

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

The Claims Administrator's Internally Developed Guidelines

These are a set of guidelines developed specifically by the Claims Administrator, as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting the Claims Administrator's medical policies for benefit plan coverage.

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

The Claims Administrator delegates its utilization review process to its affiliate, Independence Healthcare Management, a state- licensed utilization review entity. In certain instances, the Claims Administrator 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 Claims Administrator'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 Claims Administrator to its contracted behavioral health management company which administers the behavioral health benefits for the majority of the Claims Administrator's Members.

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 Claims Administrator will provide access to Covered Services first and apply the applicable COB rules later;
- Allow the Claims Administrator 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 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 \$100 per day or less and, if provided under the Member's Program, coverage for vision expenses. If so, the Claims Administrator 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 Claims Administrator will provide access to Covered Services first and determine liability later.

If it is determined that this Program is the secondary plan, the Claims Administrator 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 Claims Administrator. 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 Claims Administrator 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 AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, you agree that the Claims Administrator has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to you for an injury or illness.

The Claims Administrator retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

Subrogation Rights

Subrogation rights arise when the Claims Administrator pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Claims Administrator is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Claims Administrator "stands in your shoes" – and assumes your right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Claims Administrator has reimbursed you for medical expenses or paid medical expenses on your behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not you pursue the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery — regardless of how it's described or structured — from a Responsible Third Party, the Member must fully reimburse the Claims Administrator for all

medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The Claims Administrator has a right to full reimbursement.

Lien

By accepting benefits for Covered Services from the Claims Administrator you agree to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by you, or anyone acting on your behalf, from any Responsible Third Party. As a result, you must repay to the Claims Administrator the full amount of the medical expenses that were paid to you or on your behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Claims Administrator to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Claims Administrator has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Claims Administrator is reimbursed in full.

Constructive Trust

If you (or anyone acting on your behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), you agree to maintain the funds in a separate, identifiable account and that the Claims Administrator has a lien on the monies. In addition you agree to serve as the trustee over the monies for the benefit of Claims Administrator to the full extent that the Claims Administrator has reimbursed you for medical expenses or paid medical expenses on your behalf, plus the attorney's fees and the costs of collection incurred by the Claims Administrator.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Claims Administrator is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Claims Administrator to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Claims Administrator will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Claims Administrator will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Claims Administrator agrees to do so in writing. The recovery rights of the Claims Administrator will not be reduced by the "common fund" doctrine.

- In addition to any coordination of benefits rules described in this booklet, the benefits paid by the Claims Administrator will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Claims Administrator is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on your part.

Obligations of Member

- Immediately notify the Claims Administrator or its designee in writing if you assert a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Claims Administrator or its designee in writing whenever a Responsible Third Party contacts you or your representative - or you or your representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until you receive written authorization from the Claims Administrator or its delegated representative.
- Fully cooperate with the Claims Administrator and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Claims Administrator ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Claims Administrator or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) you or for your benefit by any Responsible Third Party to the full extent the Claims Administrator paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

IMPORTANT: Failure to Cooperate

If you fail or refuse to sign forms or documents as requested or otherwise fail or refuse to cooperate or abide by any of the obligations described above, the Claims Administrator or Plan Administrator, as applicable, has full discretion and authority to reduce or withhold benefit

payments to recover subrogation/reimbursement amounts that are owed and/or to terminate your participation in the benefit program.

CLAIM PROCEDURES

Most claims are filed by Providers in the Claims Administrator's network. The following applies if the Member must submit a claim.

Notice of Claims

The Claims Administrator will not be liable for any claims under this Program unless proper notice is furnished to the Claims Administrator that Covered Services in this Program have been rendered to a Member.

Written notice of a claim must be given to the Claims Administrator 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 Claims Administrator that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a claim to the Claims Administrator.

The Member can give notice to the Claims Administrator 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 Claims Administrator. Written proof of loss must be provided to the Claims Administrator within 90 days after the charge for Covered Services is Incurred. Proof of loss must include all data necessary for the Claims Administrator to determine benefits. Failure to submit a proof of loss to the Claims Administrator 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 Claims Administrator 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 their personal representative) is required to submit a proof of loss for benefits under this Program, it must be submitted to the Claims Administrator on the appropriate claim form. The Claims Administrator, 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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.

Physical Examinations and Autopsy

The HMO at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under the Contract; and the HMO shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

Payment of Claims

If any indemnity of the Contract shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, the HMO may pay such indemnity, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by the HMO to be equitably entitled thereto. Any payment made by the HMO in good faith pursuant to this provision shall fully discharge the HMO to the extent of such payment.

Time Limit on Certain Defenses

After three (3) years from the date of issue of the Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a claim incurred commencing after the expiration of such three (3) year period.

Legal Action

No legal action may be commenced against the Health Benefit Plan with respect to the Contract until at least sixty (60) days after the Health Benefit Plan has received a properly completed claim form, Referral or encounter form. No legal action against the Health Benefit Plan with respect to the Contract may be filed later than three (3) years after the Covered Services or supplies were performed or provided.

In addition, no legal action regarding a Complaint or Grievance may be commenced against the Health Benefit Plan until the Member has exhausted their administrative remedies and appeals as detailed in this Contract.

COMPLAINT AND GRIEVANCE APPEAL PROCESS RESOLVING PROBLEMS

MEMBER COMPLAINT PROCESS

The Claims Administrator has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on the Identification Card or write to the Claims Administrator at the following address:

**General Correspondence
1901 Market Street
Philadelphia, PA 19103**

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated and the Member will receive a response in writing within **30 days**.

MEMBER APPEAL PROCESS

Filing an Appeal - The Claims Administrator maintains procedures for the resolution of Member appeals. Member appeals may be filed within **180 days** of the receipt of a decision from the Claims Administrator stating an adverse benefit determination. An appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the appeal, the Member must complete a valid authorization form. The Member must contact the Claims Administrator as directed below to obtain a Member/Enrollee Authorization to appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member (Designee), may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

**Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274 or
Philadelphia Fax: 215-988-6558**

Definitions

MEDICAL NECESSITY APPEAL – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include appeals of adverse benefit determinations based on the exclusions for Experimental/Investigative or cosmetic services.

ADMINISTRATIVE APPEAL - An appeal by or on behalf of a Member that focuses on unresolved member disputes or objections regarding the Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, claims payment issues, participating or Non-Participating healthcare Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions). Although an Administrative Appeal may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

PRE-SERVICE REVIEW – A request for benefits that, under the terms of this Program, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained, in order for coverage to be available.

POST-SERVICE REVIEW – A request for benefits that is not a Pre-Service request. (Post-Service Reviews concerning claims for services that the Member has already obtained do not qualify for review as Urgent/Expedited Appeals.)

URGENT/EXPEDITED/ APPEAL – 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. This process is handled by the Plan Administrator.

General Information

The Member/Designee may at any time request the aid of a plan employee in preparing the appeal, at no charge. This employee has not participated in the previous decision to deny coverage for the issues in dispute and is not a subordinate of anyone who previously reviewed the file.

The Member/Designee is entitled to a full and fair review. Specifically, at any time during the process, the Member/Designee may submit additional information pertaining to the case, to the Claims Administrator. The Member/Designee may specify the remedy or corrective action being sought. At the Member's request, the Claims Administrator will provide access to, and copies of, all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Claims Administrator will automatically provide the Member/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/Designee at no charge.

The Claims Administrator will not terminate or reduce an ongoing course of treatment without providing the Member/Designee with advance notice and the opportunity for advanced review.

If the appeal is upheld, 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/Designee may request copies of this information at no charge. The letter explains the scientific or clinical judgment, if applicable, for the determination. The letter also indicates the qualifications of the individual/individuals who decided the appeal and their understanding of the nature of the appeal. The Member/Designee may request in writing, at no charge, the name of the individuals who participated in the decision to uphold the denial.

If the health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the appeal the Member may have the right to bring civil action under Section 502(a) of the Act.

Changes in Members Grievance Processes: Please note that the Appeals Process described here may change at any time due to changes in the applicable regulations and/or accreditation standards, to improve or facilitate the review process, or to reflect other decisions regarding the administration of the Member Appeals processes for this Program.

All Internal Appeals can be initiated by contacting:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274

INTERNAL APPEALS - There are two levels of appeal. The internal, standard appeal process for Administrative Appeals and Medical Necessity Appeals consists of two internal levels of review—the first by the Claims Administrator and a second by the Plan Administrator. Further review, if any, is only available through the Plan Administrator. There is also an internal Urgent/Expedited Appeal Process available through the Plan Administrator in the event **the Member's** condition involves an issue that may jeopardize the Member's life, health, ability to regain maximum function, or would subject **the Member** to severe pain that cannot be adequately managed, as determined and validated by the Member's Physician, if reviewed in **standard Pre-Service appeal timeframes.**

Level One Standard Appeal

The initial request for an appeal will be evaluated and the decision completed within the following timeframes for a standard appeal on an Administrative or Medical Necessity Appeal issue:

Standard Pre-Service service Appeal – within **15 days** of receipt of the Appeal request;
Standard Post-Service service Appeal – within **30 days** of receipt of the Appeal request.

An employee of the Claims Administrator, who has had no previous involvement with the case and who is not the subordinate of anyone involved in the previous determination, reviews the appeal. A Medical Necessity Appeal is decided by a health professional. This individual holds an active, unrestricted license to practice medicine or another health profession. Additionally, either this individual or an independent consultant is of the same profession and similar specialty that typically manages the care under review.

The Member/Designee will be sent written notice of the First Level decision within the timeframe stated above along with a description on how the Member/Designee can appeal to the next level.

Level Two Standard Appeal

If not satisfied with the First Level decision, the Member or designee may request a Second Level Appeal within **60 days** of receipt of the First Level decision notice.

Under the appeal process in effect for this Program, the Plan Administrator is responsible for the standard Second Level Administrative Appeal and Medical Necessity Appeal processes. Once the request for a Second Level Standard Appeal is received, the Claims Administrator forwards the request and all Appeal documents to the Plan Administrator for a determination. The Plan Administrator advises the Member/Designee of the decision regarding the Administrative Appeal or Medical Necessity Appeal and of any additional Appeal rights that may be available for an external review.

Urgent/Expedited Appeals

Under the appeal process in effect for this Program, the Plan Administrator is responsible for the Expedited Administrative Appeal and Expedited Medical Necessity Appeal processes. Once the request for an Urgent/Expedited Appeal is received, the Claims Administrator forwards the request and all appeal documents in its possession to the Plan Administrator. The Plan Administrator advises the Member/Designee of the decision regarding the Expedited Administrative Appeal or Medical Necessity Appeal and of any additional appeal rights that may be available for an external review.

RESOLVING PROBLEMS

MEMBER COMPLAINT PROCESS

The Claims Administrator has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on the Identification Card or write to the Claims Administrator at the following address:

**General Correspondence
1901 Market Street
Philadelphia, PA 19103**

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated and the Member will receive a response in writing within **30 days**.

MEMBER APPEAL PROCESS

Filing an Appeal - The Claims Administrator maintains procedures for the resolution of Member appeals. Member appeals may be filed within **180 days** of the receipt of a decision from the Claims Administrator stating an adverse benefit determination. An appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the appeal, the Member must complete a valid authorization form. The Member must contact the Claims Administrator as directed below to obtain a Member/Enrollee Authorization to appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member (Designee), may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

**Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274 or
Philadelphia Fax: 215-988-6558**

Definitions

MEDICAL NECESSITY APPEAL – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include appeals of adverse benefit determinations based on the exclusions for Experimental/Investigative or cosmetic services.

ADMINISTRATIVE APPEAL – An appeal by or on behalf of a Member that focuses on unresolved member disputes or objections regarding the Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, claims payment issues, participating or Non-Participating healthcare Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions). Although an Administrative Appeal may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

PRE-SERVICE REVIEW – A request for benefits that, under the terms of this Program, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained, in order for coverage to be available. A maximum of 15 days is available for each of the two (2) levels of Internal Review available for a Standard Pre-Service Appeal

POST-SERVICE REVIEW – A request for benefits that is not a Pre-Service request. (Post-Service Reviews concerning claims for services that the Member has already obtained do not qualify for review as Urgent/Expedited Appeals.) A maximum of 30 days is available for each of the two levels of Internal Review available for a Standard Post-Service Appeals.

URGENT/EXPEDITED/ APPEAL – 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. The Claims Administrator will notify the Member/Designee of the decision within 72 hours of receipt of the request by the Claims Administrator.

General Information

The Member/Designee may at any time request the aid of a plan employee in preparing the appeal, at no charge. This employee has not participated in the previous decision to deny coverage for the issues in dispute and is not a subordinate of anyone who previously reviewed the file.

The Member/Designee is entitled to a full and fair review. Specifically, at any time during the process, the Member/Designee may submit additional information pertaining to the case, to the Claims Administrator. The Member/Designee may specify the remedy or corrective action being sought. At the Member's request, the Claims Administrator will provide access to, and copies of, all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Claims Administrator will automatically provide the Member/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/Designee at no charge.

The Claims Administrator will not terminate or reduce an ongoing course of treatment without providing the Member/Designee with advance notice and the opportunity for advanced review.

If the appeal is upheld, 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/Designee may request copies of this information at no charge. The letter explains the scientific or clinical judgment, if applicable, for the determination. The letter also indicates the qualifications of the individual/individuals who decided the appeal and their understanding of the nature of the appeal. The Member/Designee may request in writing, at no charge, the name of the individuals who participated in the decision to uphold the denial.

If the health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the appeal the Member may have the right to bring civil action under Section 502(a) of the Act.

Changes in Members Grievance Processes: Please note that the Appeals Process described here may change at any time due to changes in the applicable regulations and/or accreditation standards, to improve or facilitate the review process, or to reflect other decisions regarding the administration of the Member Appeals processes for this Program.

All Internal Appeals can be initiated by contacting:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820
Toll Free 1-888-671-5276 (TTY: 711)
Toll Free Fax 1-888-671-5274

INTERNAL APPEALS

Level One Standard Appeal

The initial request for an internal appeal will be reviewed and the decision completed within the following timeframes for a standard appeal on an Administrative or Medical Necessity Appeal issue:

Standard Pre-Service service Appeal – within **15 days** of receipt of the Appeal request;
Standard Post-Service service Appeal – within **30 days** of receipt of the Appeal request.

An employee of the Claims Administrator, who has had no previous involvement with the case and who is not the subordinate of anyone involved in the previous determination, reviews the internal appeal. A Medical Necessity Appeal is decided by a health professional. This individual holds an active, unrestricted license to practice medicine or another health profession. Additionally, either this individual or an independent consultant is of the same profession and similar specialty that typically manages the care under review.

The Member will be sent written notice of the First Level decision within the timeframe stated above along with a description on how the Member can appeal to the next level.

Level Two Standard Appeal

If not satisfied with the First Level decision, the Member/Designee may request a Second Level Appeal within **60 days**. The appeal will be reviewed and the decision completed within the following timeframes for an Appeal on an Administrative or Medical Necessity Appeal issue:

Standard Pre-Service Appeal – within **15 days** of receipt of the appeal request;
Standard Post-Service Appeal – within **30 days** of receipt of the appeal request.

The Member/Designee has the right to present the Member's Appeal to the Second Level Appeal Committee in person or via conference call. The committee is composed of an employee/employees of the Claims Administrator who have no previous involvement with the case and are not subordinates of anyone previously involved with the case. For Medical Necessity reviews, at least one of these individuals is a Plan Medical Director who holds an active, unrestricted license. Second Level Appeal Committee meeting is a forum where Members/Designees each have an equal amount of time to present their issues in an informal setting that is not open to the public. Two other people may accompany the Member/Designee, unless the Member receives prior approval from the Claims Administrator for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members/Designees may not audiotape, videotape, or transcribe the committee proceedings. The Claims Administrator will contact the Member/Designee to schedule the Committee meeting for the Standard Appeal. The Appeal review may also occur based on the Appeal record without the Member's participation if he/she does not want to participate or repeated attempts to schedule the Member's participation fail. Written notice of the second level decision will be sent within the timeframes stated above.

The second level decision is the final standard level of internal appeal. The external review process for both Medical Necessity and Administrative Appeals is described under the section entitled "External Standard and Expedited Reviews" below.

Urgent/Expedited Appeals

If the case involves an urgent condition, the Member/Designee may request an Urgent/Expedited Internal Appeal. The Internal Appeal mirrors the process described under the “Level Two Standard Appeal” above.

A determination is made and the Member/Designee is notified within 72 hours of receipt of the Urgent/Expedited request by the Claims Administrator. Additionally, the Claims Administrator sends written notification to the Member/Designee within three calendar days of the verbal decision.

Individuals 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 Urgent/Expedited Appeal Process.

Additional Appeal rights for both Medical Necessity and Administrative Appeals are described below under “External Standard and Expedited Reviews.”

EXTERNAL STANDARD AND URGENT/EXPEDITED REVIEWS

If the Member/Designee is not satisfied with the decision of the Internal Standard Second Level or Urgent/Expedited Appeal, the Member/Designee may file an external review—Standard or Expedited—as described below for either an Administrative or Medical Necessity issue. Both types of external review are submitted to Independent Review Organizations (IROs).

External Standard Review

The Member/Designee may request an external review by an IRO by calling or writing to the Claims Administrator within **180 calendar days** of receipt of the Internal Appeal decision letter. The Member/Designee is not required to pay any of the costs associated with the external review.

The Member/Designee is sent written confirmation of receipt of his/her external review request from the Claims Administrator within five business days of receipt of the request. This confirmation includes the name and contact information for the Claims Administrator staff person assigned to facilitate the processing of the Member’s Appeal and information on the IRO assignment. Information on the IRO assignment identifies the assigned IRO by name and states the qualifications of the individual who reviews the appeal.

Whenever possible, the IRO assigned to the external review request, is a different organization than the one that supplied the same/or similar specialty review for the internal Appeal process. The individual appointed by the IRO to review the Member’s external review, has not been previously involved in any aspect of decision-making on the appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Claims Administrator, with the Member, or the Designee. The Claims Administrator’s arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Claims Administrator assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched

specialist for the internal appeal process, nor a subordinate of that person. If the Member/Designee feels that a conflict exists, he/she should call or write the contact person listed on the acknowledgement letter from the Claims Administrator no later than two business days from receipt of the acknowledgment letter from the Claims Administrator.

Within 15 calendar days of receipt of the Member's request, the Claims Administrator sends the Member/Designee and the IRO, a letter listing all documents forwarded to the IRO. These documents include copies of all information submitted for the Internal Appeal process, as well as any additional information that the Member/Designee or the Claims Administrator may submit. If the Member wishes to submit additional information for consideration by the IRO, he should do so within ten calendar days of the Member's request for an external review.

The Claims Administrator does not interfere with the IRO's proceedings or appeals decisions. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the Internal Appeal process.

The IRO makes its final decision within **30 calendar days** of receipt of the Member's request by the Claims Administrator and simultaneously issues its decision in writing to the Member or Designee and to the Claims Administrator. The established deadline for a decision from the IRO may only be exceeded for good cause when a reasonable delay for a specific period is acceptable to the Member or Designee. If the decision of the IRO is that the services are covered, the Claims Administrator authorizes the service and/or pays the claims. The Member/Designee is notified in writing of the time and procedure for claim payment or approval of the service in the event of an overturn of the Member's Internal Appeal. The Claims Administrator implements the IRO's decision within the time period, if any, specified by the IRO.

The external review decision is binding on the Claims Administrator.

External Urgent/ Expedited Review

The Member/Designee may request an external review for urgent/expedited situations through an IRO. The Member or designee is not required to pay any of the costs associated with the external review.

With the exception of time frames, the Urgent/Expedited External Review mirrors the process described above under the External Standard Review.

Within **24 hours** of receipt of the Member's request for an Urgent/Expedited Review, the Claims Administrator confirms the request and faxes the request to the assigned IRO. During this time, the Claims Administrator also forwards to the IRO, by secure electronic transmission or overnight delivery, all information submitted in the Internal Appeal Process and any additional information that the Member, Designee, or the Claims Administrator wishes to submit to the IRO.

The IRO makes a decision and simultaneously notifies the Member/Designee and the Claims Administrator in writing within **48 hours** of receipt of all relevant documentation. The decision letter identifies the assigned IRO by name and states the qualifications of the individual that the IRO appoints to review the external review.

The time period for issuing the final decision on the Urgent/Expedited Review can be extended for **five calendar days** for good cause when such a delay is acceptable to the Member or his authorized representative.

If the decision of the IRO is that the services are eligible, the Claims Administrator authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment and/or approval of the service in the event of an overturn of the appeal. The Claims Administrator implements the IRO's decision within the time period, if any, specified by the IRO.

The external review decision is binding on the Claims Administrator

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 Administrative Services Only Agreement ("Agreement"); is between the Group and Keystone. Keystone provides access to a network of health care providers. 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 words and symbols. Keystone, which is entering into the contract, is not contracting as an agent of the national Association. Keystone shall be liable to the Enrollee only for those obligations stated under the Agreement. This paragraph does not add any obligations to the Agreement.

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 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.

Administrative Services Only Agreement

The agreement for Administrative Services entered into between: The Group and the Claims Administrator whereby the Group has requested that the Claims Administrator provide certain administrative, claims and managed care services, in connection with this Program.

Acupuncture

A therapeutic procedure performed by the insertion of one or more specially manufactured solid metallic needles into a specific location(s) on the body. The intent is to stimulate Acupuncture points, with or without subsequent manual manipulation.

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 Claims Administrator under a

special pricing arrangement with Participating Facility Provider(s) unless the Participating Facility Provider's contractual arrangement with the Claims Administrator provides otherwise.

- For services provided by a Participating Professional Provider, "Allowed Amount" is the Claims Administrator's fee schedule amount.
- For services provided by Participating Ancillary Service Providers. "Allowed Amount" means the amount that the Claims Administrator has negotiated with the Participating Ancillary Service Provider as total reimbursement for the Covered Services.

Alternative Therapies/Complementary Medicine

Complementary and alternative medicine is defined as a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine based on recognition by the National Institutes of Health.

Ambulatory Surgical Facility

A facility operated, licensed or approved as an Ambulatory Surgical Facility by the responsible state agency, which provides specialty or multispecialty outpatient surgical treatment or procedure that is not located on the premises of 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
- Has been approved by the Claims Administrator.

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.

Artificial Insemination

The medical process of helping a woman become pregnant by:

- Taking sperms from a partner or donor;
- Inserting these sperms into a woman's vagina or uterus;
- Taking the above steps, without there needing to be any physical contact between the man and the woman.

The process includes simple sperm preparation, sperm washing and/or thawing.

Attention Deficit Disorder

A disease that makes a person have a hard time paying attention; be too impulsive; and be overly active.

Autism Service Provider

A person, entity or group that provides treatment of Autism Spectrum Disorders (ASD), using an ASD Treatment Plan, and that is either:

- Licensed or certified in this Commonwealth; or
- Enrolled in the Commonwealth's medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law.

An Autism Service Provider shall include a Behavioral Specialist.

Autism Spectrum Disorders (ASD)

Any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

Autism Spectrum Disorders Treatment Plan (ASD Treatment Plan)

A plan for the treatment of Autism Spectrum Disorders:

- Developed by a licensed Physician or licensed Psychologist who is a Participating Professional Provider; and
- Based on a comprehensive evaluation or reevaluation, performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

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.

Behavioral Specialist

An individual with appropriate certification or licensure by the applicable state, who designs, implements or evaluates a behavior modification intervention component of an ASD (Autism Spectrum Disorder) Treatment Plan, through Applied Behavioral Analysis which includes:

- Skill acquisition and reduction of problematic behavior;
- Improve function and/or behavior significantly; or
- Prevent loss of attained skill or function.

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 Claims Administrator. A charge shall be considered Incurred on the date the service or supply was provided to the Member.

Benefits Administrator

The person or entity designated by the Group to perform specific responsibilities, including but not limited to, administrative and reporting activities associated with this Program, such as assisting Members with their questions or notifying the Claims Administrator of new Members or enrollment changes (marital status, address, eligibility for Medicare). The Benefits Administrator is not the Health Benefit Plan.

Birth Center

A Facility Provider approved by the Claims Administrator 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 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.

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 enterostomal 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 Claims Administrator'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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

This definition does not include:

- A Grievance appeal (Medical Necessity appeal); or
- Disputes or objections that were resolved by the Claims Administrator 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.

Consumable Medical Supply

Non-durable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not useful to a person in the absence of illness or injury.

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.

Convenience Packs

A combination of two or more individual drug products into a single package with a unique national drug code. Products included in a convenience pack may include prescription products, over-the-counter products, and/or products not approved by the Food and Drug Administration (FDA).

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 Service

A service or supply specified in this Benefit Booklet for which benefits will be provided by the Claims Administrator.

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.

Deductible

A specified amount of Covered Services that must be paid by the Member, each Benefit Period before benefits are provided for any remaining Covered Services. A specific dollar amount that the Member's Program may require that the Member pay out-of-pocket each year, before their health insurance program begins to make payments for claims. This amount does not include Copayments amounts, any amounts above the Allowed Amount for specific Provider, or the amount for any services not covered under this Benefit Booklet.

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 Claims Administrator coverage; and
- Who meets all of the eligibility requirements established by the Group and the Claims Administrator as described in the Eligibility section of the **General Information** section of this Benefit Booklet.

Designated Provider

A Participating Provider with whom the Claims Administrator 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/Alcohol Or Drug Abuse And Dependency 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)

An individual of a Domestic Partnership consisting of two people each of whom:

- Is unmarried, at least eighteen (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 (6) 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 (3) 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 Benefits 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 Claims Administrator. This list shall be subject to periodic review and modification by the Claims Administrator.

Durable Medical Equipment (DME)

Equipment that meets the following criteria:

- It is durable and can withstand repeated use;
- It is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;
- It generally is not useful to a person in the absence of an illness or injury;and
- 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 Claims Administrator.

Elective Abortion

Is a voluntary termination of pregnancy other than one which is necessary to prevent the death of a woman, or to terminate a pregnancy that was caused by rape or incest.

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 or with respect to a pregnant Member, the health of the pregnant Member or her unborn child, 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 Claims Administrator 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 Claims Administrator; and
- Together with any amendments or modifications to that written request.

Essential Health Benefits

A set of health care service categories that must be covered by certain plans in accordance with the Affordable Care Act. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/Investigative Services

A drug, biological product, device, medical treatment or procedure, or diagnostic test, 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.

Any drug, biological product, device, medical treatment or procedure, or diagnostic procedure, is not considered Experimental/Investigative if it meets all of the criteria listed below:

- When required the drug, biological product, device, medical treatment or procedure, or diagnostic test, must have final approval from the appropriate governmental regulatory bodies (e.g. FDA).
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test, meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic tests, leads to measurable improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test, 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 in the paragraph above, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure, or diagnostic test, 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.

Any 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 a drug or biological product (e.g. infusable agent) for another diagnosis or condition shall require that one or more of the established reference Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

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 the 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 Claims Administrator.

Grievance

A request by the Member or a health care Provider with the written consent of the Member to have the Claims Administrator 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 Claims Administrator 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 Claims Administrator, and did not result in the filing of a Grievance appeal (written or oral).

Group

The entity which established, sponsors, and/or maintains a welfare benefit plan for the purpose of providing health insurance benefits to plan Members or their beneficiaries, and which, on behalf of the welfare benefit plan, has agreed to remit payments to the Claims Administrator and to receive, on behalf of the enrolled Members, any information from the Claims Administrator related to the benefits provided to enrolled Members pursuant to the terms of the Administrative Services Only Agreement.

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 the Claims Administrator'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 the Claims Administrator'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.

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 Claims Administrator.

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 Claims Administrator.

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;
 - Nursing home;
 - A school;
 - Custodial Care home;
 - Health resort;
 - Spa or sanitarium;
 - Place for provision of rehabilitation care;
 - Place for treatment of pulmonary tuberculosis;
 - Place for rest;
 - 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 Claims Administrator.

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 Claims Administrator 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 Claims Administrator 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 Claims Administrator provides coverage for

- The administration of the Immunization, and
- The agent used for Immunization.

The Claims Administrator 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 in the Preventive Schedule document.

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.

Independent Review Organization (IRO)

An entity qualified by applicable licensure and/or accreditation standards to act as the independent decision maker on external Grievance appeals requiring evaluation of issues related to Medical Necessity and appropriateness of a Participant's request for Covered Services. The Claims Administrator arranges for the availability of IROs and assigns them to external Grievance appeals. IROs are not corporate affiliates of the Claims Administrator.

Infertile Condition (Infertility or Infertile)

The condition of a healthy Member who is unable to conceive or produce conception after a one year period of unprotected sexual intercourse.

Infertility Program

A program administered by the Claims Administrator which consists of:

- The evaluation of Infertile members in order to determine the appropriate Infertility treatment;
- Determination of eligibility for the Infertility Program;
- Referral by the Primary Care Physician and Preapproval to receive Assisted Fertilization Techniques.

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;
- Extended care facility; or
- Facility Provider.

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 Claims Administrator")

A health maintenance organization providing access to comprehensive health care to Members.

Licensed Clinical Social Worker

A social worker who:

- 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 Disease Or Condition (for Qualifying Clinical Trials)

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 (Standard).

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.

Master's 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator researches all scientific information available from these expert sources.
- Following this analysis, the Claims Administrator:
 - 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.

A Member or their Provider should contact the HMO to determine whether a proposed treatment is considered “emerging technology” and whether the provider is considered an eligible provider to perform the “emerging technology” Covered Service. The HMO maintains the discretion to limit eligible Providers for certain “emerging technology” Covered Services.

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 Behavioral Health/Alcohol Or Drug Abuse And Dependency 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 or Autism Spectrum Disorders.
- The benefit limits for Mental Illness, Serious Mental Illness, and Autism Spectrum Disorders are separate and not cumulative.

Naturally Slim®

A clinical behavioral weight loss program, using informative videos and learning tools to teach the Member how to lose weight and improve the Member's health. The on-line program is available via the Member's:

- Desktop;
- Laptop; or
- Mobile device.

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 Provider

A Facility Provider, Professional Provider, Ancillary Service Provider that is NOT a member of the Claims Administrator'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.

Out-Of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum dollar amount that a Member pays for Covered Services in each Benefit Period. The Out-of-Pocket Maximum includes Copayments, Coinsurance, and Deductible amounts, if applicable, for Essential Health Benefits. 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 an 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 Claims Administrator's network.

Participating Professional Provider

A Professional Provider who is a member of the Claims Administrator's network.

Participating Provider

A Facility Provider, Professional Provider, or Ancillary Services Provider with whom the Claims Administrator 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. The Member may designate a Participating Obstetrician and Gynecologist as their PCP. For children, the Member may designate a pediatrician as the PCP.

- Referred Specialist

A Provider who provides Covered Specialist Services within their 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 Claims Administrator. 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 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 Member who provides Covered Services without a Referral.

Participating obstetricians and gynecologists have the same responsibilities as Referred Specialist. 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 Claims Administrator to provide Covered Services to Members.

- Durable Medical Equipment (DME) Provider
A Participating Provider of Durable Medical Equipment that has contracted with the Claims Administrator 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 Claims Administrator'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. Behavior Specialists are contracted to provide Covered Services for treatment of Autism Spectrum Disorders 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 Administrator

The person or entity that has discretionary authority or responsibility to control and manage the operation and administration of the Program, as provided in the documents establishing the Program, in accordance with Employee Retirement Income Security Act (ERISA). The Claims Administrator is not the Plan Administrator.

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) (Medical)

The approval which the Primary Care Physician or Referred Specialist must obtain from the Claims Administrator to confirm the Claims Administrator 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 Claims Administrator 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 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.

Prenotification (Prenotify)

The requirement that a Member provide prior notice to the Claims Administrator 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 Claims Administrator:

- 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 Order or Refill Maximum

The maximum dollar amount a Member will pay toward Covered Drugs or Supplies per Prescription Drug Order or Refill. The maximum dollar amount that applies is shown in the ***Schedule of Covered Services***.

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 with an unrestricted, unsanctioned license, who is licensed, where required, and performing services within the scope of such licensure. Professional Providers include, but are not limited to:

- Audiologist;
- Autism Service Provider;
- Behavioral Specialist;
- Certified Registered Nurse;
- Chiropractor;
- Dentist;
- Independent Clinical Laboratory;
- Licensed Clinical Social Worker;
- Master's Prepared Therapist;
- Nurse Midwife;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- 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 Claims Administrator.

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 Claims Administrator, 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.

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 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 Claims Administrator as a Qualifying Clinical Trial.

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.

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 Claims Administrator.

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 Claims Administrator, 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.

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 Claims Administrator, 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.

Respiratory Therapy

Medically prescribed treatment of diseases or disorders of the respiratory system with:

- Therapeutic gases delivered by inhalation; and
- Vaporized medications delivered by inhalation.

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 Administrative Services Only Agreement 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 Statistical 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

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 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.
- Some Generic Drugs are included in this category and are subject to the Specialty Drug cost-sharing.

The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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.

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

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 agents used to kill or slow the growth of cancerous cells.
- 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 Claims Administrator.

- Pulmonary Rehabilitation Therapy
- 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.

- Rehabilitation Therapy Services

Covered therapies include:

- Occupational
- Physical
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 locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.
- Hand
- Speech
Medically Prescribed treatment of speech and language disorders due to disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.
- Lymphedema
- Orthoptic/pleoptic
Medically Prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from vision disorder, eye Surgery, or injury. Treatment involves a program which includes evaluation and training sessions.
- Respiratory Therapy

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 your 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).

IMPORTANT NOTICES

Regarding Non-Discrimination Rights

The Member has the right to receive health care services without discrimination:

- based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity;
- for medically necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- related to gender transition if such denial or limitation results in discriminating against a transgender individual.

RIGHTS AND RESPONSIBILITIES

To obtain a list of Rights and Responsibilities, log onto www.ibx.com/members/quality_management/member_rights.html, or the Member can call the Customer Service telephone number listed on their ID Card.

LANGUAGE AND COVERAGE CHANGES

2020 PREVENTIVE SCHEDULE

This schedule is a reference tool for planning your preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your health care provider is always your best resource for determining if you're at increased risk for a condition. Some services may require precertification/preapproval. If you have questions about this schedule, precertification/preapproval, or your benefit coverage, please call the Customer Service number on the back of your ID card.

PREVENTIVE CARE SERVICES FOR ADULTS

VISITS	
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: <ul style="list-style-type: none"> • High blood pressure screening • Behavioral counseling for skin cancer • Obesity Screening 	One exam annually for all adults
SCREENINGS	
Abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males age 65 to 75 years with a history of smoking
Abnormal blood glucose and Type 2 diabetes mellitus screening and intensive counseling interventions	Abnormal blood glucose and type 2 diabetes screening for adults 40 to 70 years who are overweight or obese Intensive behavioral counseling interventions for individuals 40 to 70 years who are overweight or obese with abnormal blood glucose up to 24 sessions per year
Colorectal cancer screening	Adults age 50 to 75 years using any of the following tests: <ul style="list-style-type: none"> • Fecal occult blood testing: once a year • Highly sensitive fecal immunochemical testing: once a year • Flexible sigmoidoscopy: once every five years • CT colonography: once every five years • Stool DNA testing: once every three years • Colonoscopy: once every 10 years
Depression screening	Annually for all adults
Hepatitis B virus (HBV) screening	All asymptomatic adults at high risk for HBV infection
Hepatitis C virus (HCV) screening	All asymptomatic adults age 18 years and older at high risk for hepatitis C virus infection or as a one-time screening for adults born between 1945 and 1965

High Blood Pressure Screening	Adults age 18 years or older with increased risk once a year Adults age 18 to 39 years with no other risk factors once every 3 to 5 years Adults age 40 years once a year
Human immunodeficiency virus (HIV) screening	All adults
Latent tuberculosis infection screening	Asymptomatic adults age 18 years or older at increased risk for tuberculosis
Lipid disorder screening	Adults 40 years or older once every 5 years
Lung cancer screening	Adults age 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years
Syphilis infection screening	All adults at increased risk for syphilis infection
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence Behavioral counseling in a primary care setting
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Behavioral interventions for weight loss	Behavioral intervention for adults with a body mass index (BMI) of 30kg/m ² or higher
Exercise Interventions for the prevention of falls	Community-dwelling adults age 65 years and older with an increased risk of falls
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults age 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors
Nutritional counseling for weight management	6 visits per year
Tobacco use counseling	All adults who use tobacco products
MEDICATIONS	
Low Dose Aspirin	Adults 50-59 years of age for the primary prevention of cardiovascular disease and colorectal cancer
Prescription bowel preparation	Adults 50 years and older when used in conjunction with a preventive colorectal cancer screening procedure (That is, flexible sigmoidoscopy, colonoscopy, virtual colonoscopy)
Statin	Adults 40-75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10 year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

IMMUNIZATIONS

Vaccine	19–21 years	22–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV) or Influenza recombinant (RIV) ^{OR}	1 dose annually				
Influenza live attenuated (LAIV)					
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td booster every 10 yrs				
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)				
Varicella (VAR)	2 doses (if born in 1980 or later)				
Zoster recombinant (RZV) (preferred) ^{OR}	2 doses				
Zoster live (ZVL)					
Human papillomavirus (HPV) Female	2 or 3 doses depending on age at initial vaccination				
Human papillomavirus (HPV) Male	2 or 3 doses depending on age at initial vaccination				
Pneumococcal conjugate (PCV13)	1 dose				
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication				
Hepatitis A (HepA)	2 or 3 doses depending on vaccine				
Hepatitis B (HepB)	2 or 3 doses depending on vaccine				
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, then booster every 5 yrs if risk remains				
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication				
Haemophilus influenzae type b (Hib)	1 or 3 doses depending on indication				

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
 Recommended vaccination for adults with an additional risk factor or another indication
 No recommendation

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	
<p>Prenatal Care Visits</p> <p>Services that may be provided during the prenatal care visits include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Preeclampsia Screening 	For all pregnant females
<p>Well-woman visits</p> <p>Services that may be provided during the well-woman visit include but are not limited to the following:</p> <ul style="list-style-type: none"> • BRCA-related cancer risk assessment • Discussion of chemoprevention for breast cancer • Intimate partner violence screening • Primary care interventions to promote and support breastfeeding • Recommended preventive preconception and prenatal care services • Tobacco use counseling • Urinary Incontinence Screening 	At least annually
SCREENINGS	
Bacteriuria screening	All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if later
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic females with either personal history or family history of a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling
Breast cancer screening (2D or 3D mammography)	All females age 40 years and older
Cervical cancer screening (Pap test)	Ages 21 to 65: Every three years Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval
Chlamydia screening	Sexually active females age 24 years and younger or older sexually active females who are at increased risk for infection
Diabetes Mellitus Screening After Pregnancy	Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus

Depression Screening	All pregnant and post-partum females
Gestational diabetes mellitus screening	Asymptomatic pregnant females after 24 weeks of gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes
Gonorrhea screening	Sexually active females age 24 years and younger or older sexually active females who are at increased risk for infection
Hepatitis B virus (HBV) screening	All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All pregnant females
Human papillomavirus (HPV) screening	Age 30 and older: Every three years Ages 30 to 65: Every five years with a combination of Pap test and HPV testing, for those that want to lengthen the screening interval
Iron-deficiency anemia screening	All asymptomatic pregnant females
Osteoporosis (bone mineral density) screening	Every two years for females younger than 65 years who are at high risk for osteoporosis Every two years for females 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition
Preeclampsia Screening	All pregnant females without a known diagnosis of preeclampsia or hypertension
RhD incompatibility screening	All pregnant females and follow-up testing for females at higher risk
Syphilis screening	All pregnant females at first prenatal visit For high-risk pregnant females, repeat testing in the third trimester and at delivery Females at increased risk for syphilis infection
Tobacco Use Counseling	All pregnant females who smoke tobacco products
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence Behavioral counseling in a primary care setting
MEDICATIONS	
Breast cancer chemoprevention	Asymptomatic females age 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention
Folic Acid	Daily folic acid supplements for all females planning for or capable of pregnancy
Low Dose Aspirin	Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation

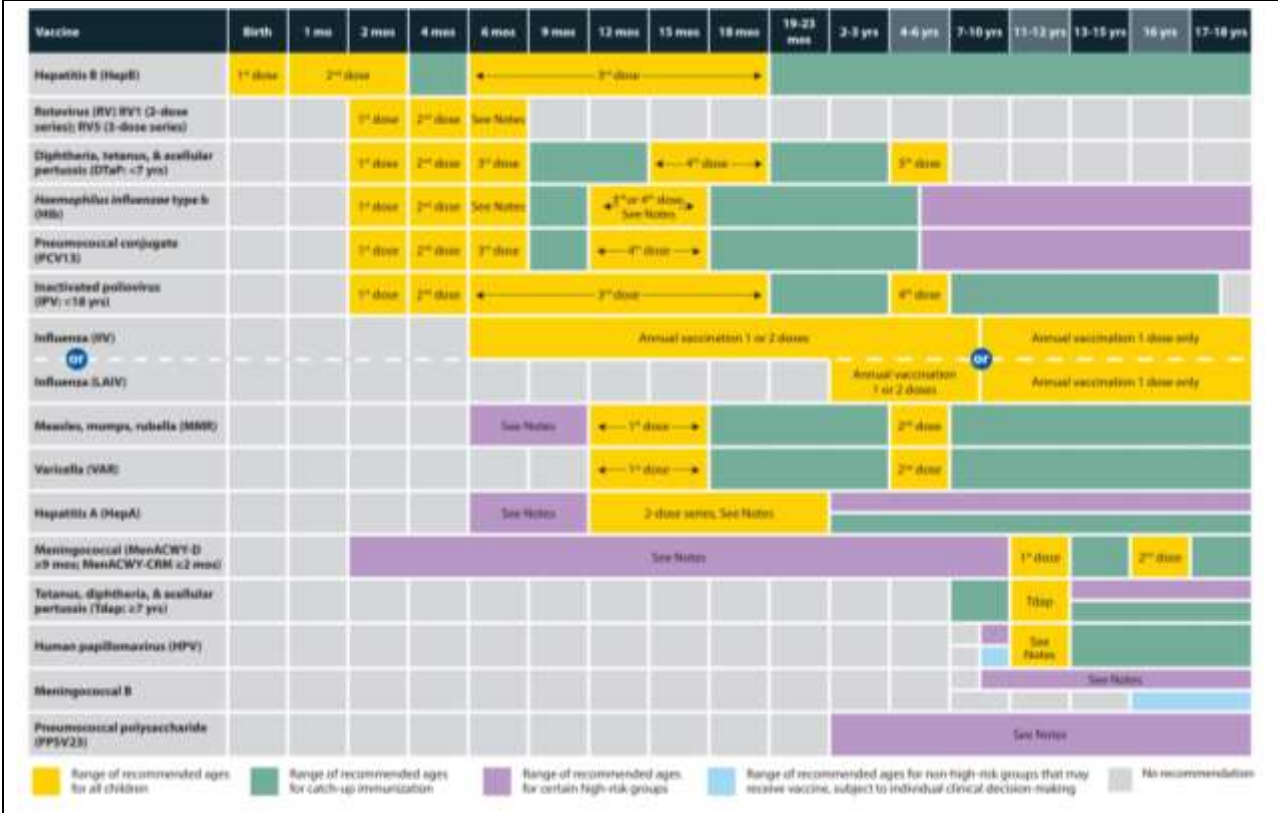
MISCELLANEOUS	
Breastfeeding supplies/support/counseling	Comprehensive lactation support/counseling for all pregnant women and during the postpartum period Breastfeeding supplies
Reproductive education and counseling, contraception, and sterilization	All females with reproductive capacity

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pre-birth exams	All expectant parents for the purpose of establishing a pediatric medical home
	All children up to 21 years of age, with preventive exams
SCREENINGS	
Alcohol, tobacco, and drug use screening and behavioral counseling intervention	Annually for all children 11 years of age and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
Autism and developmental screening	All children
Bilirubin Screening	All newborns
Chlamydia screening	All sexually active children up to age 21 years
Depression screening	Annually for all children age 12 years to 21 years
Dyslipidemia screening	Following a positive risk assessment or in children where laboratory testing is indicated
Gonorrhea screening	All sexually active children up to age 21 years
Hearing screening for newborns	All newborns
Hearing screening for children 29 days or older	Following a positive risk assessment or in children where hearing screening is indicated

Hepatitis B virus (HBV) screening	All asymptomatic adolescents at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All children
Iron Deficiency Screening	All children
Lead poisoning screening	All children at risk of lead exposure
Newborn metabolic screening panel (For example, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	All newborns
Syphilis screening	All sexually active children up to age 21 years
Vision screening	All children up to age 21 years
ADDITIONAL SCREENING SERVICES AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	Semiannually for all sexually active adolescents at increased risk for sexually transmitted infections
Obesity Screening and Behavioral Counseling	Screening is part of the preventive exam for children ages 6 years and older. Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater
MEDICATIONS	
Fluoride	Oral fluoride for children age 6 months to 16 years whose water supply is deficient in fluoride
Prophylactic ocular topical medication for gonorrhea	All newborns within 24 hours after birth
MISCELLANEOUS	
Fluoride varnish application	Twice a year for all infants and children starting at age of primary tooth eruption to 5 years of age
Tuberculosis testing	All children up to age 21 years

IMMUNIZATIONS (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)



Comprehensive Major Medical ***Health Benefits Program***

Self Referred Benefits



Benefits underwritten or administered by QCC Insurance Co., a subsidiary of Independence Blue Cross-Independent Licensees of the Blue Cross and Blue Shield Association.

COMPREHENSIVE MAJOR MEDICAL HEALTH BENEFITS GROUP BENEFIT BOOKLET

Administered by

QCC Insurance Company
(Called "Claims Administrator")
A Pennsylvania Corporation
Located at
1901 Market Street
Philadelphia, PA 19103

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية, فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deutsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Dii baa akó ninizin: Dii saad bee yánilti'go Diné Bizaad, saad bee áká'anida'áwo'déé', t'áá jiik'eh. Hódiilnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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INTRODUCTION

Thank you for joining QCC Insurance Company (Claims Administrator). Our goal is to provide Members with access to quality health care coverage. This Benefit Booklet is a summary of the Members benefits and the procedures required in order to receive the benefits and services to which Members are entitled. Members' specific benefits covered by Claims Administrator 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** sections 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 Program Document available through the Members Group benefits administrator. The information in this Benefit Booklet is subject to the provisions of the Group Program Document. If changes are made to the Members Group's Program, the Member will be notified by the Members Group benefits administrator. Group Program Document 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 Members Effective Date of coverage; or
- The Group Program Document anniversary date coinciding with or next following that service's effective date.

Please read the Benefit Booklet thoroughly and keep it handy. It will answer most questions regarding the Claims Administrator's procedures and services. **If Members have any other questions, they should call the Claims Administrator's 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 Program Document 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 Program Document 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 Group's anniversary date)
SELF-REFERRED	
Program Deductible	
Individual	\$500
Individual and Dependents	\$1,000
Family	\$1,500*
<p>* In each Benefit Period, it will be applied to all family members covered under a Family Coverage. A Deductible will not be applied to any covered family member once that covered family member has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.</p>	
Coinsurance	20% for Covered Services, except as otherwise specified in the <i>Schedule of Covered Services</i> .
Out-of-Pocket Limit	
Individual	\$2,000
Family	\$6,000
<p><i>Note for Out-Of-Pocket Limit shown above:</i> When a Member Incurs the level of Self-Referred Out-of-Pocket expenses listed above of Coinsurance expense in one Benefit Period for Self-Referred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. After the Family Self-Referred Out-of-Pocket Limit amount has been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Self-Referred Out-of-Pocket amount. Out-of-Pocket expenses Incurred for Covered Services provided by a Participating Provider count toward the Referred Out-of-Pocket Limit. The Self-Referred dollar amounts specified shall not include any expense Incurred for any Deductible, Penalty or Copayment amount.</p>	
Lifetime Maximum	Unlimited

SCHEDULE OF COVERED SERVICES

This ***Schedule of Covered Services*** is an overview of the benefits you are entitled to. More details can be found in the ***Description of Covered Services*** section.

Subject to the exclusions, conditions and limitations of this Program, a Member is entitled to benefits for the Covered Services described in this ***Schedule of Covered Services*** during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. The percentages for Coinsurance and Covered Services shown in this ***Schedule of Covered Services*** are not always calculated on actual charges. For an explanation on how Coinsurance is calculated, see the "Covered Expense" definition in the ***Important Definitions*** section.

Some Covered Services must be Precertified before the Member receives the services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the ***General Information*** section.

BENEFIT	SELF-REFERRED
Acupuncture⁽⁴⁾	20%, after Deductible
<i>Note for Acupuncture shown above: Benefit Period Maximum: 18 visits</i>	
Alcohol Or Drug Abuse And Dependency⁽³⁾	
Inpatient Hospital Detoxification and Rehabilitation	20%, after Deductible*
Hospital and Non-Hospital Residential Care	20%, after Deductible*
Outpatient Treatment	20%, after Deductible
* Benefit Period Maximum: 120 Inpatient days. This maximum is combined for all Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits.	
Ambulance Services⁽⁴⁾	
Emergency Services	None, Deductible does not apply
Non-Emergency Services	20%, after Deductible

BENEFIT	SELF-REFERRED
Autism Spectrum Disorders⁽⁴⁾	Same cost-sharing as any other medical service within the applicable medical service (For example, Therapy Services, Diagnostic Services, etc.)
<p><i>Note for Autism Spectrum Disorders shown above:</i></p> <p>Annual Benefit Maximum for non-essential benefits: \$41,271.</p> <p>This Annual Benefit Maximum is part of, not separate from, the Autism Spectrum Disorders Annual Benefit Maximum provided under your Keystone Member Benefit Booklet.</p> <p>Benefit Period Maximums and visit limits do not apply</p> <p>If this Program does not provide coverage for prescription drugs, Autism Spectrum Disorders medications are covered less the applicable Coinsurance per 30 day prescription order:</p> <p>Generic Coinsurance - 30% Brand Coinsurance - 30%</p> <p>Deductible does not apply</p>	
Blood⁽³⁾	20%, after Deductible
Colorectal Cancer Screening⁽⁴⁾	20%, after Deductible
Day Rehabilitation Program⁽⁴⁾	20%, after Deductible
<p><i>Note for Day Rehabilitation Program shown above: Benefit Period Maximum: 30 visits</i></p>	
Diabetic Education Program⁽⁴⁾	20%, Deductible does not apply
<p><i>Note for Diabetic Education Program shown above: Deductible and Maximum amounts do not apply to this benefit</i></p>	
Diabetic Equipment And Supplies⁽⁴⁾	20%, after Deductible
Diagnostic Services⁽⁴⁾	20%, after Deductible
Durable Medical Equipment And Consumable Medical Supplies⁽⁴⁾	20%, after Deductible
Emergency Care Services⁽⁴⁾	\$35 Copayment per visit (waived if admitted), Deductible does not apply
Home And Office Visits/Retail Clinics ⁽¹⁾	20%, after Deductible
Home Health Care⁽⁴⁾	20%, after Deductible
Hospice Services⁽³⁾	20%, after Deductible
<p><i>Note for Hospice Services shown above: Respite Care: Maximum of seven days every six months.</i></p>	

BENEFIT	SELF-REFERRED
Hospital Services⁽²⁾	
Facility Charge	20%, after Deductible*
Professional Charge	20%, after Deductible
* Benefit Period Maximum: 120 Inpatient days. This maximum is combined for all Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits.	
Immunizations⁽¹⁾	20%, Deductible does not apply
Injectable Medications⁽⁴⁾	20%, after Deductible
Laboratory and Pathology Tests⁽⁴⁾	20%, after Deductible
Maternity/OB-GYN/Family Services⁽³⁾	
Elective Abortions	
Professional Service	20%, after Deductible
Outpatient Facility Charges	20%, after Deductible
Maternity/Obstetrical Care	
Professional Service	20%, after Deductible
Facility Service: Inpatient/Birthing Center	20%, after Deductible
Newborn Care	20%, after Deductible

BENEFIT	SELF-REFERRED
Medical Care⁽²⁾	20%, after Deductible
Medical Foods And Nutritional Formulas⁽⁴⁾	20%, Deductible does not apply
Mental Health/Psychiatric Care⁽³⁾	
Inpatient	20%, after Deductible*
Outpatient	20%, after Deductible
* Benefit Period Maximum: 120 Inpatient days. This maximum is combined for all Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits.	
Methadone Treatment⁽⁴⁾	20%, after Deductible
Naturally Slim[®] Foundations^{TM(1)} Distributed by NS412, LLC	Not Covered
<i>Note for Naturally Slim[®] FoundationsTM shown above: Benefit Period Maximum: 10 sessions</i>	
NS4You^{TM(1)} Distributed by NS412, LLC	Not Covered
<i>Note for NS4YouTM shown above: Benefit Period Maximum: 10 sessions</i>	
Nutrition Counseling For Weight Management⁽¹⁾	20%, after Deductible
<i>Note for Nutrition Counseling For Weight Management shown above: Benefit Period Maximum: 6 visits</i>	
Orthotics⁽⁴⁾	20%, after Deductible
Preventive Care - Adult⁽¹⁾	20%, Deductible does not apply
Preventive Care - Pediatric⁽¹⁾	20%, Deductible does not apply
Private Duty Nursing Services⁽⁴⁾	20%, after Deductible
Prosthetic Devices⁽⁴⁾	20%, after Deductible
Skilled Nursing Facility Services⁽²⁾	20%, after Deductible
<i>Note for Skilled Nursing Facility Services shown above: Benefit Period Maximum: 240 Inpatient days</i>	

BENEFIT	SELF-REFERRED
Smoking Cessation⁽¹⁾	20%, after Deductible
Spinal Manipulation Services⁽⁴⁾	20%, after Deductible
Surgical Services⁽³⁾	
Outpatient Facility Charge	20%, after Deductible
Outpatient Professional Charge	20%, after Deductible
Assistant Surgeon	20%, after Deductible
Outpatient Anesthesia	20%, after Deductible
<i>Note for Outpatient Anesthesia shown above: Services administered by a nurse anesthetist not employed by a Professional Provider are paid at 50%</i>	
Second Surgical Opinion	20%, after Deductible
<i>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 Claims Administrator will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure</i>	
Telemedicine Services⁽⁴⁾	Not Covered
Therapy Services⁽⁴⁾	
Cardiac Rehabilitation Therapy, Occupational Therapy, Physical Therapy, Respiratory Therapy and Speech Therapy	20%, after Deductible
Chemotherapy	20%, after Deductible
Dialysis	20%, after Deductible
Infusion Therapy	20%, after Deductible
Orthoptic/Pleoptic Therapy	20%, after Deductible
<i>Note for Orthoptic/Pleoptic Therapy shown above: Lifetime Maximum: 8 sessions</i>	
Radiation Therapy	20%, after Deductible

BENEFIT	SELF-REFERRED
Transplant Services⁽³⁾	
Inpatient Facility Charges	20%, after Deductible
Outpatient Facility Charges	20%, after Deductible
Urgent Care Centers⁽⁴⁾	20%, after Deductible
Women's Preventive Care⁽¹⁾	20%, Deductible does not apply

- (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***

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 during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. These amounts and percentages, and other cost-sharing requirements are specified in the **Schedule of Covered Services**.

The Member will maximize the benefits available when Covered Services are provided by Participating Providers. The benefits of using these Providers include lower Coinsurance payments, no balance billing and no claim forms. The **General Information** section provides more detail regarding these benefits.

Some Covered Services must be Precertified before the Member receives the services. Precertification of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the **General Information** section.

PRIMARY AND PREVENTIVE CARE

A Member is entitled to benefits for Primary Care and Preventive Care Covered Services when deemed Medically Necessary and billed for by a Provider. Cost-sharing requirements 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 Claims Administrator reviews the schedule of Covered Services, at certain times. Reviews are based on recommendations from national organizations of:

- Physicians, including pediatricians and internists;
- National independent panels of experts in primary care and prevention;
- National not-for-profit health organizations; and
- Government advisory panels.

Accordingly, the frequency and eligibility of Covered Services are subject to change. A list of Preventive Care Covered Services can be found in the Preventive Schedule document. A complete listing of recommendations and guidelines can be found at <https://www.healthcare.gov/preventive-care-benefits/>.

The Claims Administrator reserves the right to modify the Preventive Schedule document at any time. However, the Member has to be given a written notice of the change, before the change takes effect.

Home and Office Visits/Retail Clinics

The Claims Administrator will provide coverage for Medical Care visits, by a Professional Provider, for any of the following services:

SF.KPOS/PC.BK.LG.HCR
Rev. 1.20

Group Number:10095774, 75, 76, 81, 82, 83, 84, 85, 86, 88

- The examination of an illness or injury;
- The diagnosis of an illness or injury; and
- The treatment of an illness or injury.

For the purpose of this benefit, "Office Visits" include:

- Medical Care visits to a Provider's office;
- Medical Care visits by a Provider to a Member's residence; or
- Medical Care consultations by a Provider on an Outpatient bases.

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:

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Sore throat; ▪ Ear, eye, or sinus infection; ▪ Allergies; | <ul style="list-style-type: none"> ▪ Minor burns; ▪ Skin infections or rashes; and ▪ Prenancy testing. |
|---|---|

Immunizations

The Claims Administrator will provide coverage for the following:

- Pediatric immunizations;
- Adult immunizations; and
- The agents used for the immunizations.

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

Pediatric and adult immunization schedules can be found in the Preventive Schedule document.

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

Naturally Slim® Foundations™

The Claims Administrator will provide coverage for Naturally Slim® Foundations™ services distributed by NS412, LLC, up to the Benefit Period Maximum specified in the ***Schedule of Covered Services.***

- The initial ten-week behavioral based nutritional intervention is designed to:
 - Educate Members on losing weight;
 - Increasing exercise; and
 - Making healthy lifestyle choices.
- NS412, LLC works with the Group to determine the enrollment criteria in the program based on:
 - Criteria developed and approved by NS412, LLC and the Group; and
 - Evaluation of the Member's risk for metabolic syndrome.
- Members will not be accepted into the program if the Member:
 - Is pregnant;
 - Indicates that they currently have or have had an eating disorder in the past;

- Indicates they have a health condition that would make it unadvisable by a Professional Provider to go through the program; or
- Indicates that they have a body mass index (BMI) of less than 19.

Eligible Dependents will not be able to enroll in the program.

NS4You™

The Claims Administrator will provide coverage for NS4You™ services distributed by NS412, LLC, up to the Benefit Period Maximum specified in the ***Schedule of Covered Services***.

- The ten-week behavioral-based nutritional intervention program is designed to:
 - Reinforce the principles of the Naturally Slim® Foundations™ in those Members who have previously participated in the Foundations Program.
- NS412, LLC works with the Group to determine the enrollment criteria in the program based on:
 - Criteria developed and approved by NS412, LLC and the Group; and
 - Evaluation of the Member's risk for metabolic syndrome.
- Members will not be accepted into the program if the Member:
 - Is pregnant;
 - Indicates that they currently have or have had an eating disorder in the past;
 - Indicates they have a health condition that would make it unadvisable by a Professional Provider to go through the program; or
 - Indicates that they have a body mass index (BMI) of less than 19.

Eligible Dependents will not be able to enroll in the program.

Nutrition Counseling for Weight Management

The Claims Administrator 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 Specialist; or
- By a Registered Dietitian (RD).

This benefit is in addition to any other nutrition counseling Covered Services described in this Benefit Booklet.

Preventive Care - Adult

The Claims Administrator will provide coverage for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

Preventive Care - Pediatric

The Claims Administrator will provide coverage for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

Smoking Cessation

Smoking cessation includes clinical preventive services rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) as described under the Preventive Services provision of the Patient Protection and Affordable Care Act.

Women's Preventive Care

The Claims Administrator will provide coverage for an initial physical examination for pregnant women to confirm pregnancy, screening for gestational diabetes, and other Covered Services, in accordance with the Preventive Schedule document. Covered Services and Supplies include, but are not limited to, the following:

- Routine Gynecological Exam, Pap Smear: Members are covered for one 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*.
- Mammograms: Coverage will be provided for screening mammograms. The Claims Administrator will only provide coverage for benefits for mammography if the following applies:
 - It is performed by a qualified mammography service provider.
 - That service provider 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 Durable Medical Equipment supplier 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 when provided by a Participating Provider.
- 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 when provided by a Participating Provider.

If a Member's Physician determines that they require more than one well-women visit annually to obtain all recommended preventive services (based on the women's health status, health needs and other risk factors), the additional visit(s) will be provided without cost-sharing.

INPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Inpatient Care are Covered Services when they are:

- Deemed Medically Necessary;
- Provided by a Facility Provider and billed by a Provider; and
- Preapproved by the Claims Administrator.

Look in the Schedule of Covered Services section to find how much of those or other costs the Member is required to share (pay).

Hospital Services

▪ Ancillary Services

The Claims Administrator 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 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.
- 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 Claims Administrator 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 Claims Administrator 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.

Benefits are provided up to the number of days specified in the ***Schedule of Covered Services***.

In computing the number of days of benefits:

- The Claims Administrator will count the day of the Member's admission; but not the day of the Member's discharge.
- If the Member is admitted and discharged on the same day, it will be counted as one day.

The Claims Administrator will only provide coverage for days spent during an uninterrupted stay in a Hospital.

It will not provide coverage for:

- Time spent outside of the Hospital, if the Member interrupts the stay and then stay past midnight on the day the interruption occurs; or
- Time spent in the Hospital after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

Medical Care

The Claims Administrator 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 Professional Provider who is in charge of the case;
- While the Member is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility; and
- For a condition not related to Surgery, pregnancy, radiation therapy or Mental Illness.

Such care includes Inpatient intensive Medical Care rendered to the Member:

- While the Member's condition requires a Professional Provider's 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 Professional Provider:
 - 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 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 Facility Provider's rules and regulations.

- Consultations

The Claims Administrator will provide coverage for Consultation services when rendered in both of the following ways:

- By a Professional Provider, at the request of the attending Professional Provider; and
- While the Member is an Inpatient in a:
 - Hospital;
 - Rehabilitation Hospital; or
 - Skilled Nursing Facility.

Benefits are limited to one consultation per consultant during any Inpatient confinement.

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

Skilled Nursing Facility Services

The Claims Administrator will provide coverage for a Skilled Nursing Facility:

- When Medically Necessary as determined by the Claims Administrator.
- Up to the Maximum days specified in the ***Schedule of Covered Services***.

The Member must require treatment:

- By skilled nursing personnel;
- Which can be provided only on an Inpatient basis in a Skilled Nursing Facility.

In computing the number of days of benefits:

- The Claims Administrator will count the day of the Member's admission; but not the day of the Member's discharge.
- If the Member is admitted and discharged on the same day, it will be counted as one day.

The Claims Administrator will only provide coverage for days spent during an uninterrupted stay in a Skilled Nursing Facility.

It will not provide coverage for:

- Time spent outside of the Skilled Nursing Facility, if the Member interrupts their stay and then stays past midnight on the day the interruption occurs;
- Time spent if the Member remains past midnight of the day on which the interruption occurred; or
- Time spent in the Skilled Nursing Facility after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

INPATIENT/OUTPATIENT SERVICES

The Member is entitled to benefits for Covered Services while the Member is an Inpatient in a Facility Provider or on an Outpatient basis when both of the following happen:

- Deemed Medically Necessary; and
- Billed for by a Provider.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

Blood

The Claims Administrator 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 drugs in the official formularies; and
 - Which have not been replaced by a donor.

Hospice Services

The Claims Administrator will provide coverage for palliative and supportive services provided to a terminally ill Member through a Hospice program by a Hospice Provider. This also includes Respite Care.

- Who is eligible: The Member will be eligible for Hospice benefits if both of the following occur:
 - The Member's attending Physician certifies that the Member has a terminal illness, with a medical prognosis of six months or less; and
 - 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 Claims Administrator 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

- Elective Abortions
The Claims Administrator will provide coverage for services provided in a Facility Provider that is a Hospital or Birth Center. It also includes services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member, which is a Covered Expense under this Program.
- Maternity/Obstetrical Care
The Claims Administrator will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.
 - Pre-notification - The Claims Administrator 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 Claims Administrator will provide coverage for:
 - Facility services: Provided by a Facility Provider that is a Hospital or Birth Center; and
 - Professional services: Performed by a Professional Provider or certified nurse midwife.
 - Scope of Care - The Claims Administrator will provide coverage for:
 - Prenatal care; and
 - Postnatal care.
 - Type of delivery - Maternity care Inpatient benefits will be provided for:
 - 48 hours for vaginal deliveries; and
 - 96 hours for cesarean deliveries.

Except as otherwise approved by the Claims Administrator.

 - 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/Psychiatric Care

The Claims Administrator will provide coverage for the treatment of Mental Illness and Serious Mental Illness based on the services provided and reported by the Provider. Upon request, the Claims Administrator will make available the criteria for Medical Necessity determinations made under the Program for Mental Health/Psychiatric Care to any current or potential Member, Dependent or In-Network Provider.

- Regarding the provision of care other than Mental Health/Psychiatric Care: When a Provider renders Medical Care, other than Mental Health/Psychiatric Care, for a Member with Mental Illness and Serious Mental Illness, payment for such Medical Care:
 - Will be based on the Medical Benefits available; and
 - Will not be subject to the Mental Health/Psychiatric Care limitations.

- Inpatient Treatment

The Claims Administrator will provide coverage, subject to the Benefit Period limitation(s) stated in the **Schedule of Covered Services**, during an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness.

Covered Services include treatments such as:

- Psychiatric visits;
- Psychiatric consultations;
- Individual and group psychotherapy;
- Electroconvulsive therapy;
- Psychological testing; and
- Psychopharmacologic management.

- Outpatient Treatment

The Claims Administrator will provide coverage for Outpatient treatment of Mental Illness and Serious Mental Illness.

Covered Services include treatments such as:

- Psychiatric visits;
- Psychiatric consultations;
- Individual and group psychotherapy;
- Licensed Clinical Social Worker visits;
- Masters Prepared Therapist visits
- Tele-Behavioral Health services;
- Electroconvulsive therapy;
- Psychological testing;
- Psychopharmacologic management; and
- Psychoanalysis.

- Benefit Period Maximums for Mental Health/Psychiatric Care

All Inpatient Mental Health/Psychiatric Care for both Mental Illness and Serious Mental Illness are covered up to the Maximum day amount per Benefit Period specified in the **Schedule of Covered Services**.

Routine Patient Costs Associated With Qualifying Clinical Trials

- The Claims Administrator 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 Claims Administrator 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 Professional Provider, and conducted in a Participating Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider, then the Claims Administrator 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 Claims Administrator.

Surgical Services

The Claims Administrator will provide coverage for surgical services provided:

- By a Professional Provider, and/or a 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 Claims Administrator will provide coverage for the following when performed after a mastectomy:
 - All stages of reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prosthesis and physical complications all stages of mastectomy, including lymphedemas; and
 - 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" of this section; and
 - Routine neonatal circumcisions, any voluntary surgical procedure for sterilization and any Surgery performed for the reversal of a sterilization procedure.

- Anesthesia
 - The Claims Administrator will provide coverage for the administration of Anesthesia:
 - In connection with the performance of Covered Services;
 - When rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider (except an Obstetrician providing Anesthesia during labor and delivery and an oral surgeon providing services otherwise covered under this Benefit Booklet).
 - General Anesthesia, along with hospitalization and all related medical expenses normally Incurred as a result of the administration of general Anesthesia, when rendered in conjunction with dental care provided to Members age seven or under and for developmentally disabled Members when determined by the Claims Administrator to be Medically Necessary and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

- Assistant at Surgery

The Claims Administrator 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 Claims Administrator.

Surgical assistance is not covered when performed by a Professional Provider who themselves performs and bills for another surgical procedure during the same operative session.

- Hospital Admission for Dental Procedures or Dental Surgery

The Claims Administrator 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 Claims Administrator will provide coverage for Covered Services provided by a Professional Provider and/or Facility Provider for:

 - 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.

To the extent that the Member has available dental coverage, the Claims Administrator reserves the right to seek recovery from the Provider.

The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Claims Administrator deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

▪ Second Surgical Opinion (Voluntary)

The Claims Administrator 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 Professional Provider other than the one who initially recommended performing the Surgery.

Transplant Services

When a Member is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants, which are beyond the Experimental/Investigative stage. Benefits, are also provided for those services to the Member which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of Blood provided to a Member:

- When both the recipient and the donor are Members, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under this Program. The 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 coverage by the Claims Administrator or any government program. When only the recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under this Program.
- When only the donor is a Member, the donor is entitled to the benefits of this Program for all

related donor expenses, subject to the following additional limitations:

- The benefits are limited to only those benefits not provided or available to the donor from any other source for funding or coverage in accordance with the terms of this Program; and
- No benefits will be provided to the donor 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.

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 Claims Administrator will provide coverage for the care and treatment of Alcohol Or Drug Abuse And Dependency:
 - Provided by a licensed Hospital or licensed Facility Provider or an appropriately licensed behavioral health Provider.
 - Subject to the Maximum shown in the ***Schedule of Covered Services***; and
 - According to the provisions outlined below.
- To Access Treatment for Alcohol Or Drug Abuse And Dependency:
 - Call the behavioral health management company at the phone number shown on the Members ID Card.

Upon request, the Claims Administrator will make available the criteria for Medical Necessity determinations made under the Program for Alcohol Or Drug Abuse And Dependency to any current or potential Member, Dependent or In-Network Provider.

- Inpatient Treatment

- Inpatient Detoxification
Covered Services include:
 - Lodging and dietary services;
 - Physician, Psychologist, nurse, certified addictions counselor, Masters Prepared Therapists, and trained staff services;
 - Diagnostic x-rays;
 - Psychiatric, psychological and medical laboratory testing; and
 - Drugs, medicines, use of equipment and supplies.
- Hospital and Non-Hospital Residential Treatment
Hospital or Non-Hospital Residential Treatment of Alcohol Or Drug Abuse And Dependency shall be covered on the same basis as any other illness covered under this Program.

Covered services include:

- Lodging and dietary services;
- Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
- Rehabilitation therapy and counseling;
- Family counseling and intervention;
- Psychiatric, psychological and medical laboratory testing; and
- Drugs, medicines, use of equipment and supplies.

- Outpatient Treatment
 - Covered services include:
 - Diagnosis and treatment of substance abuse, including Outpatient Detoxification by the appropriately licensed behavioral health Provider;
 - Appropriately licensed behavioral health providers including Physician, Psychologist, nurse, certified addictions counselor, Masters Prepared Therapists, and trained staff services;
 - Rehabilitation therapy and counseling;
 - Family counseling and intervention;
 - Psychiatric, psychological and medical laboratory testing; and
 - Medication management and use of equipment and supplies.

OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Outpatient Care are Covered Services when:

- Deemed Medically Necessary; and
- Billed for by a Provider.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

Acupuncture

The Claims Administrator will provide coverage for Acupuncture up to the limits specified in the ***Schedule of Covered Services*** for all Covered Services.

Ambulance Services/Transport

The Claims Administrator will provide coverage for ambulance services. However, these services need to be:

- Medically Necessary as determined by the Claims Administrator; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when 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 health or be inappropriate for 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.

In addition, the Claims Administrator will provide coverage for services provided by a licensed Emergency services Provider who initiates necessary intervention to evaluate and, if necessary, stabilize the condition of the Member and subsequently determines the Member does not require transport or the Member refuses to be transported. These services must be Medically Necessary as determined by the Claims Administrator.

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 transports: Non-Emergency air or ground facility transport may be covered when Medically Necessary as determined by the Claims Administrator (For example, sending facility does not have the required services to effectively treat the Member, such as trauma or burn care). Non-Emergency air or ground transport may be covered to transport the Member back to an In-Network Facility Provider as determined by the Claims Administrator, when:
 - The transfer is Medically Necessary (as determined by the Claims Administrator's definition of Medical Necessity); and
 - The Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance.

Non-Emergency ambulance transports are not provided for family members or companions or for the convenience of the Member, the family, or the Provider treating the Member.

Autism Spectrum Disorders (ASD)

The Claims Administrator will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Members under 21 years of age subject to the Annual Benefit Maximum specified in the ***Schedule of Covered Services***.

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician assistant, licensed Psychologist or Certified Registered Nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than 12 months, unless a licensed Physician or licensed Psychologist determines an earlier assessment is necessary.

Treatment of Autism Spectrum Disorders shall be identified in an ASD Treatment Plan and shall include any Medically Necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is:

- Prescribed, ordered or provided by a licensed Physician, licensed Physician assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner;
- Provided by an Autism Service Provider, including a Behavior Specialist; or
- Provided by a person, entity or group that works under the direction of an Autism Service Provider.

An ASD Treatment Plan shall be developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The ASD Treatment Plan may be reviewed by the Claims Administrator once every six months. A more or less frequent review can be agreed upon by the Claims Administrator and the licensed Physician or licensed Psychologist developing the ASD Treatment Plan.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed Physician or licensed Psychologist:

- Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- Pharmacy Care - Medications prescribed by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner to determine the need or effectiveness of such medications. If this Program provides benefits for prescription drugs the ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable to the prescription drug coverage. If this Program does not provide coverage for prescription drugs, ASD medications may be purchased at a pharmacy, and the Member will be reimbursed at 100% less the applicable Coinsurance amount shown in the **Schedule of Covered Services**. Benefits are available for up to a 30 day supply.
- Psychiatric Care - Direct or consultative services provided by a Physician who specializes in psychiatry.
- Psychological Care - Direct or consultative services provided by a Psychologist.
- Rehabilitative Care - Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- Therapeutic Care - Services provided by speech language pathologists, occupational therapists or physical therapists.

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a Member shall be entitled to file an Appeal. The Appeal process will:

- Provide internal review followed by independent external review; and
- Have levels, expedited and standard Appeal time frames, and other terms established by the Claims Administrator consistent with applicable Pennsylvania and federal law.

Appeal filing procedures will be described in notices denying any Autism Spectrum Disorders benefits. Full Appeal process descriptions will be provided after a new Appeal is initiated and can also be obtained at any time by contacting Member Services.

Colorectal Cancer Screening

The Claims Administrator will provide coverage for colorectal cancer screening for Symptomatic Members, Nonsymptomatic Members over age 50, and Nonsymptomatic Members under age 50 who are at high risk or increased risk for colorectal cancer. Coverage for colorectal cancer screening must be in accordance with the current American Cancer Society guidelines, and consistent with approved medical standards and practices. The method and frequency of screening to be utilized shall be:

- Coverage for Symptomatic Members shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.
- Coverage for Nonsymptomatic Members over age 50 shall include, but not be limited to:
 - An annual fecal occult blood test;
 - A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years; and
 - A colonoscopy at least once every ten years.
- Coverage for Nonsymptomatic Members under age 50 who are at high or increased risk for colorectal cancer shall include a colonoscopy or any combination of colorectal cancer screening tests.

"Nonsymptomatic Member at high or increased risk" means a Member who poses a higher than average risk for colorectal cancer according to the current American Cancer Society guidelines on screening for colorectal cancer.

"Symptomatic Member" means a Member who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

Consumable Medical Supplies

The Claims Administrator will provide coverage for the purchase of Consumable Medical Supplies when:

- It is used in the Member's home; and
- It is obtained through a Professional Provider.

Day Rehabilitation Program

The Claims Administrator will provide coverage for a Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

- Intensity of need for therapy: The Member must require intensive Therapy services, such as Physical, Occupational and/or speech Therapy 5 days per week for 4 to 7 hours per day;
- Ability to communicate: The Member must have the ability to communicate (verbally or non-verbally); their needs; they must also have the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff;
- Willingness to participate: The Member must be willing to participate in a Day Rehabilitation Program; and
- Family support: The Member's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

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

Diabetic Education Program

When prescribed by a Professional Provider legally authorized to prescribe such items under law, the Claims Administrator 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.

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; and
 - Be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Claims Administrator.

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 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 Claims Administrator 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 requirements applicable to Durable Medical Equipment benefits.
- 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.

* **Note:** Insulin and oral agents are not covered as Self-Referred benefits. They are covered as Referred benefits only.

Diagnostic Services

The Claims Administrator will provide coverage for the following Diagnostic Services, when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

- Diagnostic x-rays, consisting of radiology, mammograms, ultrasound, and nuclear medicine;
- Diagnostic laboratory and pathology tests.
- Diagnostic medical procedures consisting of ECG, EEG, Sleep Studies, and other diagnostic medical procedures approved by the Claims Administrator.
- Allergy testing, consisting of percutaneous, intracutaneous and patch 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 Claims Administrator, 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 Claims Administrator will provide coverage for the rental or, at the option of the Health Benefit Plan, the purchase of Durable Medical Equipment when:

- Prescribed by a Professional Provider and required for therapeutic use; and
- Determined to be Medically Necessary by the Claims Administrator.

Although an item may be classified as Durable Medical Equipment it may not be covered in every instance. Durable Medical Equipment, as defined in the **Important Definitions** section, that includes equipment that meets the following criteria:

- It is durable and can withstand repeated use. An item is considered durable if it can withstand: repeated use, (That is, the type of item that could normally be rented). Medical Supplies of an expendable nature are not considered "durable" (For example, see the "Non-reusable supplies" provisions of the "Durable Medical Equipment" exclusion of the **Exclusions - What Is Not Covered** section of this Program);
- It customarily and primarily serves a medical purpose;
- It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the Member's illness, injury, or to improvement of a malformed body part; and
- It is appropriate for home use.

- **Replacement and Repair:**
The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

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 Claims Administrator in the case of rented equipment; and
- The Member in the case of purchased equipment.

Breakage during reasonable useful lifetime: The Claims Administrator 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 Claims Administrator will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.)

Cost to repair vs. cost to replace: The Claims Administrator 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.

Emergency Care Services

- Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are covered by the Claims Administrator.
- Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency.
- Examples of an Emergency include:

<ul style="list-style-type: none"> – Heart attack; – Loss of consciousness or respiration – Cardiovascular accident; – Convulsions; 	<ul style="list-style-type: none"> – Severe Accidental Injury; and; – Other acute medical conditions as determined by the Claims Administrator.
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Note: Should any dispute arise as to whether an Emergency existed or as to the duration of an Emergency: The determination by the Claims Administrator shall be final.

Home Health Care

- Covered Services: The Claims Administrator 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: The Claims Administrator will also provide coverage 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 Claims Administrator.
- 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 Claims Administrator 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.

Injectable Medications

The Claims Administrator will provide coverage for injectable medications required in the treatment of an injury or illness when administered by a Professional Provider.

- Specialty Drugs
 - Refer 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.To obtain a list of Specialty Drugs please logon to www.ibx.com/preapproval or Call the Customer Service telephone number shown on the Member's Identification Card.
- Standard Injectable Drugs
 - Standard Injectable Drugs refer to a medication that is either injectable or infusible, but is

not defined by the Claims Administrator 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 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** section.

Medical Foods and Nutritional Formulas

- The Claims Administrator 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 Claims Administrator will provide coverage for Nutritional Formulas when the Nutritional Formula is taken orally or through a tube by an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

An estimated basal caloric requirement for Medical Foods and Nutritional Formula is not required for IEMs, or for when administered through a tube.

Non-Surgical Dental Services

The Claims Administrator 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. Injury as a result of chewing or biting is not considered an Accidental Injury. See the exclusion of dental services in the **Exclusions - What Is Not Covered** section for more information on what dental services are not covered.

Orthotics (Devices Used for Support of Bones and Joints)

The Claims Administrator 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 Claims Administrator. 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.

Private Duty Nursing Services

The Claims Administrator will provide coverage up to the number of hours specified in the **Schedule of Covered Services** for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician and which are Medically Necessary as determined by the Health Benefit Plan.

Prosthetic Devices

The Claims Administrator will provide coverage for expenses Incurred for Prosthetic Devices (except dental prostheses) required as a result of illness or injury. Expenses for Prosthetic Devices are subject to medical review by the Claims Administrator to determine eligibility and Medical Necessity.

Such expenses may include, but not be limited to:

- The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ;
- The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
- Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive Surgery incident and subsequent to mastectomy; and
- Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
 - Initial contact lenses prescribed for 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
 - Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of:
 - Accidental Injury;
 - Trauma; or
 - Ocular Surgery.

The repair and replacement provisions do not apply to this item.

Benefits for replacement of a Prosthetic Device or its parts will be provided:

- When there has been a significant change in the Member's medical condition that requires the replacement;
- If the prostheses breaks because it is defective;
- If the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer; or
- For a Dependent's child due to the normal growth process when Medically Necessary.

The Claims Administrator will provide benefits to repair Prosthetic Devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of the prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Health Benefit Plan will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

If a Prosthetic Device breaks and is under warranty, it is the responsibility of the Member to work with the manufacturer to replace or repair it.

Spinal Manipulation Services

The Claims Administrator 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 for, up to the limits specified in the ***Schedule of Covered Services*** for spinal manipulations.

Telemedicine Services

- Services Provided by a contracted vendor
Telemedicine services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone or secure video when a primary care physician is unavailable or inaccessible. These licensed vendors do not replace an existing primary care physician relationship but enhances it with an efficient, cost-effective alternative for non-emergency medical problems. The applicable vendor Provider cost-sharing requirements are specified in the ***Schedule of Covered Services***. The Member will pay the applicable cost-sharing via credit or debit card prior to the consultation.
- Benefits Provided by Professional Provider
Telemedicine services are also covered, when provided by a Professional Provider and subject to the relevant cost-share applicable to that Provider. The Provider's eligibility will be determined by the Claims Administrator in the Claims Administrator's policies, who is licensed in the state where the telemedicine service is being offered. Telemedicine services are covered when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA) - compliant interactive audio and video telecommunications system as specified in the Claims Administrator's policies

Therapy Services

The Claims Administrator will provide coverage, subject to the Benefit Period Maximums specified in the **Schedule of Covered Services**, for the following services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Member.

- Cardiac Rehabilitation Therapy
Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- Chemotherapy
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided if it meets all of the criteria listed below:
 - Drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents;
 - The FDA approved indication is based on reliable evidence demonstrating positive effect on health outcomes and/or the indication is supported by the established referenced Compendia identified in the Health Benefit Plan's policies; and
 - Drugs/biologics are eligible for coverage when they are injected or infused into the body by a Professional Provider.

Note: If this Program does not provide coverage for prescription drugs, oral antineoplastic agents are covered as provided under the benefits described above.

- Dialysis
The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).
- Infusion Therapy
The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a Professional 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 Professional 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 Claims Administrator.
- Occupational Therapy
Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

- Orthoptic/Pleoptic Therapy
Includes treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye Surgery, or injury resulting in the lack of vision depth perception.
- 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, including the treatment of functional loss following hand and/or foot Surgery.
- 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.
- 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 Claims Administrator 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 Professional Provider or Retail Clinic.
- Cost-sharing requirements are specified in the ***Schedule of Covered Services***.

EXCLUSIONS – WHAT IS NOT COVERED

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

Alternative Therapies/Complementary Medicine

For Alternative Therapies/Complementary Medicine, including but not limited to:

- 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/Transport

For ambulance services/transport except as specifically provided under this Program.

Assisted Fertilization Techniques

For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT).

Autism

- For Autism Spectrum Disorders services that exceed the Annual Benefit Maximum shown in the ***Schedule of Covered Services***.
- For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
- For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

Benefit Maximums

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

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).

Consumable Medical Supplies

For Consumable Medical Supplies, any item that meets the following criteria is not a covered Consumable Medical Supply and will not be covered:

- The item is for comfort or convenience.
- The item is not primarily medical in nature. Items not covered include, but are not limited to:
 - Ear plugs;
 - Ice pack;
 - Silverware/utensils;
 - Feeding chairs; and
 - Toilet seats.
- The item has features of a medical nature which are not required by the member's condition.
- The item is generally not prescribed by an eligible Provider.

Some examples of not covered Consumable Medical Supplies are:

- Incontinence pads;
- Lamb's wool pads;
- Face masks (surgical);
- Disposable gloves, sheets and bags;
- Bandages;
- Antiseptics; and
- Skin preparations.

Cosmetic Surgery

For services and operations for cosmetic purposes

- Which are done to improve the appearance of any portion of the body; and
- From which no improvement in physiologic function can be expected.

However, benefits are payable to correct:

- A condition resulting from an accident; and
- Functional impairment which results from a covered disease, injury or congenital birth defect.

This exclusion does not apply to mastectomy related charges as provided for and defined in the "Surgical Services" section in the ***Description of Covered Services***.

Cranial Protheses (Including Wigs)

For cranial protheses, including wigs intended to replace hair.

Dental Care

- 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 atopic 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).

Diagnostic Screening Examinations

For diagnostic screening examinations, except for mammograms and preventive care as provided in the "Primary and Preventive Care", "Women's Preventive Care" and "Diagnostic Services" subsections of the ***Description of Covered Services***.

Durable Medical Equipment

For the following examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

- Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.
- Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.
- Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as:
 - Diathermy machines;
 - Medcolator;
 - Data transmission devices used for telemedicine purposes;
 - Pulse tachometer;
 - Translift chairs; and
 - Traction units.
- Non-reusable supplies other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment.
- Equipment 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" in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to:
 - Equipment For Safety;
 - Exercise equipment;
 - Speech teaching machines;
 - Strollers;
 - Toileting systems;
 - Electronically-controlled heating and cooling units for pain relief;
 - Bathtub lifts;
 - Stairglides; and
 - Elevators.

- Equipment with features of a medical nature which are not required by the Member's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medical Necessity and realistically feasible alternative item that serves essentially the same purpose.
- Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.
- Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment.
- Modifications to vehicles, dwellings and other structures. This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Member's disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as customization to a wheelchair.

Effective Date

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

Experimental/Investigative

Which are Experimental/Investigative in nature, except, as approved by the Claims Administrator, Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Benefit Booklet.

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.

Hearing Aids

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

Cochlear electromagnetic hearing devices, a semi-implantable Hearing Aid, is not covered. Cochlear electromagnetic hearing devices are not considered cochlear implants.

High Cost Technical Equipment

For equipment costs related to services performed on high cost technological equipment as defined by the Claims Administrator, such as, but not limited to:

- Computer Tomography (CT) scanners;
- Magnetic Resonance Imagers (MRI); and
- Linear accelerators.

Unless the acquisition of such equipment by a Professional Provider was approved:

- Through the Certificate of Need (CON) process; and/or
- By the Claims Administrator.

Home Blood Pressure Machines

For home blood pressure machines, except for Members:

- With pregnancy-induced hypertension;

Medical Foods And Nutritional Formulas

- For appetite suppressants;
- For oral non-elemental nutritional supplements (For example, Boost, Ensure, NeoSure, PediaSure, Scandishake), casein hydrolyzed formulas (For example, Nutramigen, Alimentun, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, and soy-based products. 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**.
- For elemental semi-solid foods (For example, Neocate Nutra);
- For products that replace fluids and electrolytes (For example, Electrolyte Gastro, Pedialyte);
- For oral additives (For example, Duocal, fiber, probiotics, or vitamins) and food thickeners (For example, Thick-It, Resource ThickenUp); and
- For supplies associated with the oral administration of formula (For example, bottles, nipples).

Medical Supplies

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

Medical Necessity

Which are not Medically Necessary as determined by the Claims Administrator for the diagnosis or treatment of illness or injury.

Medications

For any medications other than prescription drugs, unless administered during an Inpatient Admission.

Mental Health/Psychiatric Care

- For vocational or religious counseling; and
- For activities that are primarily of an educational nature.

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

- 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 telephone consultations.
- For completion of a claim form.
- For marriage counseling.
- For Custodial Care, domiciliary care or rest cures.
- Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Service Provider" except as otherwise indicated under the subsections entitled:

- "Therapy Services"; and
- "Ambulance Services/Transport" in the **Description of Covered Services** section.
- 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".
- **For any Therapy Service provided for:**
 - Work hardening activities/programs; or
 - Evaluations not associated with therapy.

Motor Vehicle

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

Any services, supplies or treatments not specifically listed as covered benefits in this Program, which are paid to or on behalf of a Member by the Keystone HMO contract under which the Member is enrolled as an Employee or eligible Dependent of an enrolled Group, when that person is also concurrently covered as an Employee or Dependent of that same enrolled Group under this Program. Any Copayment or Deductible amounts required by the Keystone HMO contract are also excluded.

Obesity

For treatment of obesity, including, but not limited to:

- Weight management programs;
- Dietary aids, supplements, injections and medications;
- Weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician; and
- Group nutrition counseling.

This exclusion does not apply to:

- Surgical procedures specifically intended to result in weight loss (including bariatric surgery) when the Claims Administrator:
 - Determines the Surgery is Medically Necessary; and
 - The Surgery is limited to one surgical procedure per lifetime regardless (or even) if:
 - A new or different diagnosis is the indication for the Surgery;
 - A new or different type of Surgery is intended or performed;
 - A revision, repeat, or reversal of any previous weight loss Surgery is intended or performed.

The exclusion of coverage for a repeat, reversal or revision of a previous Surgery does not apply when the intended procedure is performed to treat technical failure or complication of a prior surgical procedure which if left untreated, would result in endangering the health of the Member. Failure to maintain weight loss or any condition resulting from or associated with obesity does not constitute technical failure.

- Nutrition counseling visits/sessions as described in the "Nutrition Counseling for Weight Management" provision in this Benefit Booklet.

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;
- Wigs;
- Chairlifts;
- Stairglides;
- Elevators;
- Sauna;
- Television;
- Spa or health club memberships;
- Whirlpool;
- 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

- For prescription drugs.

Preventive Services

For preventive services, except as specifically provided under the in the "Primary and Preventive Care" subsection of the ***Description of Covered Services***.

Private Duty Nursing

- For Private Duty Nursing services in connection with the following:
 - Nursing care which is primarily custodial in nature; such as care that primarily consists of bathing, feeding, exercising, homemaking, moving the patient and giving oral medication;
 - Services provided by a nurse who ordinarily resides in the Member's home or is a member of the Member's Immediate Family; and
 - Services provided by a home health aide or a nurse's aide.
- For Inpatient Private Duty Nursing services.

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 Services**.

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

Claims paid or payable by Medicare when Medicare is primary. For purposes of this Program exclusion, coverage is not available for a service, supply or charge that 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. The amount excluded for these claims will be either the amount "payable under Medicare" or the applicable plan fee schedule for the service, at the discretion of the Claims Administrator.

Routine Foot Care

As defined in the Claims Administrator's Medical Policy unless associated with Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes.

Self-Administered Prescription Drugs

For Self-Administered Prescription Drugs, 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:

- 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 Free-Standing Prescription Drug Contract issued to the Group by the Claims Administrator; or
- Required for treatment of an Emergency condition that requires a Self-Administered Prescription Drug.

Sexual Dysfunction

For sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist.

Skilled Nursing Facility

For Skilled Nursing Facility services in connection with the following:

- When confinement in a Skilled Nursing Facility 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 treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension.

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 Disorders;
- Learning disabilities;
- Behavioral problems;
- Intellectual disability;
- Treatment or care to effect ;
environmental or social change; or
- Autism Spectrum Disorders.

Except as otherwise provided in this Program.

Travel

For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider.

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 for members of the armed forces of any nation on active duty.

Vision

- For correction of myopia or hyperopia by means of corneal microsurgery, such as:
 - Keratomileusis;
 - Keratophakia;
 - Radial keratotomy and all related services.
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses except as otherwise described in this Benefit Booklet.

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 THE PROGRAM

Effective Date: The date the Group agrees that all eligible persons may apply and become covered for the benefits as set forth in this Program and described in this Benefit Booklet. If a person becomes an eligible person after the Group's Effective Date, that date becomes the eligible person's effective date under this Program.

Eligible Person

The Employee is eligible to be covered under this Program if the Employee is determined by the Group as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by the Employee's physical condition and determination of eligibility for the coverage by the employer shall be final and binding.

Eligible Dependent

The Employee's family is eligible for coverage (Dependent coverage) under this Program when the Employee is eligible for Employee coverage. An eligible Dependent is defined as the Employee's spouse under a legally valid existing marriage, the Employee's child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is the Employee's responsibility under the terms of a qualified release or court order. To determine the limiting age when coverage ends for covered children refer to the Keystone Member Benefit Booklet.

In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from an Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.

A full-time student who is eligible for coverage under this Program who is:

- A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and who is 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 Employee must submit a form to the Claims Administrator approved by the Department of Military & Veterans Affairs (DMVA):

- Notifying the Claims Administrator that the Dependent has been placed on active duty;
- Notifying the Claims Administrator that the Dependent is no longer on active duty; or

- 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 Domestic Partner is also eligible for enrollment. As long as the Domestic Partnership exists, the child or children of a Domestic Partner shall be considered for eligibility under the Program as if they were the Member's own child or children. If the Member enrolls their Domestic Partner, the Member has an affirmative obligation to notify the Claims Administrator immediately if the Domestic Partnership terminates. Upon termination of the Domestic Partner relationship, coverage of the former Domestic Partner and the children of the former Domestic Partner shall terminate at the end of the current monthly term. The former Domestic Partner, and any of their previously covered children, shall be entitled, by applying within 60 days of such termination, to direct pay coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This direct pay coverage may be different from the coverage provided under this Benefit Booklet.

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on the Employee for over half of their support. The Claims Administrator may require proof of eligibility under the prior Claims Administrator's plan and also from time to time under this Program.

The newborn child(ren) of the Employee or the Employee's Dependent shall be entitled to the benefits provided by this Program from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, the Employee must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, the Employee must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under this Program on the date the Dependent is acquired provided that the Employee applies to the Claims Administrator for addition of the Dependent within 31 days after the Dependent is acquired and the Employee makes timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after the Employee's Application is accepted by the Claims Administrator.

A Dependent child of a custodial parent covered under this Program may be enrolled under the terms of a qualified medical release or court order, as required by law.

No Dependent may be eligible for coverage as a Dependent of more than one Member of the Enrolled Group. No individual may be eligible for coverage hereunder as a Member and as a Dependent of a Member at the same time.

Benefits to Which the Member Is Entitled

The liability of the Claims Administrator is limited to the benefits specified in this Benefit Booklet. The Claims Administrator's determination of the benefit provisions applicable for the services rendered to the Member shall be conclusive.

Termination of Coverage at Termination Of Employment Or Membership In The Group

When a Member ceases to be an eligible Employee or eligible Dependent, or the required contribution is not paid, the Member's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Program are provided by and/or approved by the Claims Administrator before the Claims Administrator receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Group notified the Claims Administrator of such termination.

Consumer Rights

Each Member has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call Member Services at the toll-free number referenced on the Identification Card.

Member/Provider Relationship

- The choice of a Provider is solely the Member's choice.
- The Claims Administrator does not furnish Covered Services but only makes payment for Covered Services received by persons covered under this Program. The Claims Administrator is not liable for any act or omission of any Provider. The Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

COVERAGE CONTINUATION

Termination of the Member's Coverage and Conversion Privilege Under This Program

- Termination of this Program - Termination of the Group coverage (this Program) automatically terminates all coverage for the Member (an Enrolled Employee) and the Member's eligible Dependents. The privilege of conversion to a conversion contract shall be available to any Member who has been continuously covered under the Group Program Document for at least three months (or covered for similar benefits under any group plan that this Program replaced).

It is the responsibility of the Group or the Group's Applicant Agent to notify the Member and the Member's eligible Dependents of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

Rescission: If it is proven that the Member or the Member's eligible Dependent obtained or attempted to obtain benefits or payment for benefits, through fraud or intentional misrepresentation of material fact, the Claims Administrator, may, upon notice to the Member, terminate the coverage. The Member will receive written notice at least 30 days prior to termination but will have the right to utilize the **Complaint and Appeal Process** to appeal cancellation.

The privilege of conversion is available for the Member and the Member's eligible Dependents except in the following circumstances:

- The Group terminates this Program in favor of group coverage by another organization; or

- The Group terminates the Member in anticipation of terminating this Program in favor of group coverage by another organization.
- **Notice of Conversion** - Written notice of termination and the privilege of conversion to a conversion contract shall be given within 60 days after the date of termination of this Program. Once the Member receives notice and the Member elects a conversion plan, payment for coverage under the conversion contract must be made within 31 days. Evidence of insurability is not required. Upon receipt of this payment, the conversion contract will be effective on the date of the Member's termination under this Program.

Conversion coverage shall not be available if the Member is eligible for another health care program which is available in the Group where the Member is employed or with which the Member is affiliated to the extent that the conversion coverage would result in over-insurance.

If the Member's coverage or the coverage of the Member's eligible dependent terminates because of the Member's death, the Member's change in employment status, divorce of dependent spouse, or change in a dependent's eligibility status, the terminated Member will be eligible to apply within 31 days of termination (or termination of the continuation privileges under COBRA) to conversion coverage, of the type for which that Member is then qualified at the rate then in effect. This conversion coverage may be different from the coverage provided under this Program. Evidence of insurability is not required.

Continuation Of Coverage At Termination Of Employment Or Membership Due To Total Disability

The Member's protection under this Program may be extended after the date the Member ceases to be a Member under this Program because of termination of employment or membership in the Group. It will be extended if, on that date, the Member is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the Member remains Totally Disabled from any such illness or injury, but not beyond 12 months if the Member ceases to be a Member because the Member's coverage under this Program ends.

Coverage under this Program will apply during an extension as if the Member was still a Member. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for the Member through the Claims Administrator by the Group. Continuation of coverage is subject to payment of the applicable premium.

Continuation Of Incapacitated Child

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Member (an enrolled Employee) for over half of the child's support, the Member may apply to the Claims Administrator to continue coverage of such child under this Program upon such terms and conditions as the Claims Administrator may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 26.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 26 years of age. The disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over 26 years of age and joining the Claims Administrator for the first time, the handicapped child must have been covered under the prior health benefit plan and submit proof from the prior health benefit plan that the child was covered as a handicapped person.

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 the Employee's eligible Dependents to temporarily extend health care coverage.

INFORMATION ABOUT PROVIDER REIMBURSEMENT

The Member can get the maximum benefits from their Comprehensive Major Medical Health Benefits Program by using Participating Providers. The benefits of using these Participating Providers include:

- Lower coinsurance payments. When the Member uses a Participating Provider, the Coinsurance the Member pays will be a percentage of the contracted rate. This rate is lower than what the Provider normally charges.

The Member doesn't have to shop around for the lowest Provider costs; the Claims Administrator has done it for the Member. This means less money out of their pocket.

- No Balance Billing. Participating Providers agree to accept the amount the Claims Administrator pays, plus the Member's Coinsurance. If the Member goes to a Non-Participating Provider, unless a claim is successfully negotiated through the Price Protection Program, the Claims Administrator will pay the applicable percentage as described in the "Covered Expense" definition in the **Important Definitions** section. The Member pays the balance of this amount; plus, if the Provider charges rates higher than those normally charged in the geographic area, the Member will pay the extra amount.
- No Claim Forms. When using a Participating Provider, the Member never has to fill out a claim form.
- Precertification. To obtain a list of services that require Precertification please follow the instructions found in the **General Information** section of this Benefit Booklet. If the Member is ever unsure over whether to Precertify, call the Claims Administrator. Just use the toll-free number shown on the Member's Identification Card.

Self-Referred Benefits

The benefits described in this Benefit Booklet are the benefits provided when the Member chooses to receive Covered Services without obtaining a referral from the Member's Primary Care Physician (called "Self-Referred Care"). When the Member chooses Self Referred Care, the level of benefits are, in most cases, subject to an annual Deductible, Coinsurance payments and Lifetime and Benefit Maximums, so the Member will be responsible for a greater share of out-of-pocket expenses. The Member also may be required to file a claim form.

Some of the services the Member's receives must be Precertified before the Member receives them, to determine whether they are Medically Necessary. Failure to Precertify Self-Referred Care services, when required, may result in a reduction of benefits. The Member will be financially liable for Penalties assessed for failure to Precertify Self-Referred services.

Payment Of Benefits

Payment for Covered Services and supplies, when Medically Necessary, may vary depending on whether the Covered Service or supply was provided by a Participating or Non-Participating Provider.

- Participating Providers

Participating Providers have contractual arrangements for the provision of services to Members. Benefits will be provided as specified in the **Schedule of Covered Services** for Covered Services or supplies rendered to Members by a Participating Provider. The Claims Administrator will compensate a Participating Provider in accordance with the rate of reimbursement determined by contract. The Member's out-of-pocket Coinsurance costs will be less when the Member uses these Providers, because the Member's Coinsurance is calculated on lower contracted fees. The Claims Administrator may reimburse Providers directly for the services covered under this Program. Participating Providers will, in most instances, submit claim forms for reimbursement on the member's behalf.

- Non-Participating Providers

Non-Participating Providers do not have contractual arrangements for the provision of services to Members. When Covered Services and supplies are rendered by these Providers, the Member's Coinsurance costs may be higher, because for claims not successfully negotiated through the Price Protection Program, the Member's Coinsurance is calculated on the lesser of the allowable payment by Medicare, the Claims Administrator's proprietary fee schedule or the Provider's charges. (See the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet). For claims not successfully negotiated through the Price Protection Program, the Claims Administrator will pay benefits to the Member directly, and the Member will be responsible for paying the Provider.

- Emergency Care by Non-Participating Providers

If the Claims Administrator determines that Covered Services provided by a Non-Participating Provider were for Emergency Care, the Member will be subject to the Participating cost-sharing levels. Penalties that ordinarily would be applicable to Non-Participating Covered Services will not be applied. For Emergency Care, not successfully negotiated through the Price Protection Program, the Claims Administrator will reimburse the Member for Covered Services at the Non-Participating Provider reimbursement rate. However, if Emergency Care is provided by certain Out-of-Network Providers (For example, ambulance services), in accordance with applicable law, the Claims Administrator will reimburse the Out-of-Network Provider at an In-Network rate directly. In this instance the specified Out-of-Network Provider will not bill the Member for amounts in excess of the Claims Administrator's payment for the Emergency Care. For payment of Covered Services provided by a Non-Participating Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Claims Administrator. Payment for Emergency Services provided by Non-Participating Providers will be the negotiated amount through the Price Protection Program, or the greater of:

- The median of the amounts paid to Participating Providers for Emergency Services;
- The amount paid to Non-Participating Professional Providers; or
- The amount paid by Medicare.

Unless a claim is successfully negotiated through the Price Protection Program, a Non-Participating Provider who provided Emergency Care can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the Claims Administrator's payment for the Emergency Care (That is, balance billing). In such situations, the Member will need to contact the Claims Administrator at the Customer Service telephone number listed on the back of the Member's I.D. card. Upon such notification, the Health Benefit Plan will resolve the balance-billing.

- Non-Participating Hospital-Based Provider Reimbursement

When the Member receives Covered Services from a Non-Participating Hospital-Based Provider while the Member is an Inpatient at a Participating Hospital or other Participating Facility Provider and are being treated by a Participating Professional Provider, the Member will receive the Participating cost-sharing level of benefits for the Covered Services provided by the Non-Participating Hospital-Based Provider. For such Covered Services, not successfully negotiated through the Price Protection Program, payment will be made to the Member, who will be responsible for reimbursing the Non-Participating Hospital-Based Provider. For payment of Covered Services provided by a Non-Participating Professional Provider, please refer to the definition of "Covered Expense" in the **Important Definitions** section of this Benefit Booklet.

Unless a claim is successfully negotiated through the Price Protection Program, a Non-Participating Hospital-Based Provider can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the Claims Administrator's payment to the Non-Participating Hospital-Based Providers (That is, balance billing). In such situations, the Member will need to contact the Claims Administrator at the Customer Service telephone number listed on the back of the Member's I.D. card. Upon such notification, the Claims Administrator will resolve the balance billing.

Note that when the Member elects to see a Non-Participating Hospital-Based Provider for follow-up care or any other service where the Member has the ability to select a Participating Provider, the Covered Services will be covered at a Non-Participating benefit level. Except for Emergency Care, if a Non-Participating Provider admits the Member to a Hospital or other Facility Provider, Covered Services provided by a Non-Participating Hospital-Based Provider will be reimbursed at the Non-Participating benefit level. For such Covered Services, not successfully negotiated through the Price Protection Program, payment will be made to the Member and the Member will be responsible for reimbursing the Non-Participating Hospital Based Provider. For payment of Covered Services provided by a Non-Participating Professional Provider, please refer to the definition of “Covered Expense” in the **Important Definitions** section of this Benefit Booklet.

- Inpatient Hospital Consultations by a Non-Participating Professional Provider

When the Member receives Covered Services for an Inpatient hospital consultation from a Non-Participating Professional Provider while the Member is an Inpatient at a Participating Facility Provider, and the Covered Services are referred by a Participating Professional Provider, the Member will receive the Participating cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, not successfully negotiated through the Price Protection Program, payment will be made to the Member and the Member will be responsible for reimbursing the Non-Participating Professional Provider. For payment of Covered Services provided by a Non-Participating Professional Provider, please refer to the definition of “Covered Expense” in the **Important Definitions** section of this Benefit Booklet.

Unless a claim is successfully negotiated through the Price Protection Program, a Non-Participating Professional Provider can bill the Member directly for their services, for either the Provider’s charges or amounts in excess of the Claims Administrator’s payment to the Non-Participating Professional Providers (That is, balance billing). In such situations, the Member will need to contact the Claims Administrator at the Customer Service telephone number listed on the back of the Member’s I.D. card. Upon such notification, the Claims Administrator will resolve the balance billing.

Note that when the Member elects to see a Non-Participating Professional Provider for follow-up care or any other service when the Member has the ability to select a Participating Provider, the Covered Services will be covered at a Non-Participating benefit level. Except for Emergency Care, if a Non-Participating Professional Provider admits the Member to a Hospital or other Facility Provider, services provided by Non-Participating Professional Provider will be reimbursed at the Non-Participating benefit level. For such Covered Services, not successfully negotiated through the Price Protection Program, payment will be made to the Member and the Member will be responsible for reimbursing the Non-Participating Professional Provider. For payment of Covered Services provided by a Non-Participating Professional Provider, please refer to the definition of “Covered Expense” in the **Important Definitions** section of this Benefit Booklet.

- Non-Participating Pharmacies

With respect to Non-Participating Pharmacies, benefits will be provided to the Member at the Non-Participating Coinsurance level specified in the **Schedule of Covered Services**.

Any applicable cost-sharing specified in the **Schedule of Covered Services** will be applied to the Covered Expense amount. A Non-Participating Pharmacy is entitled to collect from the Member any cost-sharing obligation and the remaining balance due.

- Assignment of Benefits to Providers

The right of a Member to receive benefit payments under this coverage is personal to the Member and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this Program 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 this Program, as required by law.

BlueCard Program

- Out-of-Area Services

Overview

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever the Member accesses healthcare services outside of the geographic area the Claims Administrator serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When the Member receives care outside of the Claims Administrator's service area, the Member will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Claims Administrator explains below how the Claims Administrator pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by the Claims Administrator to provide the specific service or services.

- BlueCard® Program

Under the BlueCard® Program, when the Member receives Covered Services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When the Member receives Covered Services outside the Claims Administrator's service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to 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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Claims Administrator has used for the Member's claim because they will not be applied after a claim has already been paid.

– Special Cases: Value-Based Programs

BlueCard® Program

If the Member receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claims Administrator through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If the Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Member's behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

– Nonparticipating Providers Outside the Claims Administrator's Service Area

➤ Member Liability Calculation

When Covered Services are provided outside of the Claims Administrator's service area by nonparticipating providers, the amount the Member pays for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

➤ Exceptions

In certain situations, the Claims Administrator may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount the Claims Administrator will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

– Blue Cross Blue Shield Global Core

If the Member is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), the Member may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Member with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when the Member receives care from providers outside the BlueCard service area, the Member will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If the Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

➤ Inpatient Services

In most cases, if the Member contacts the service center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for the Member's deductibles, coinsurance, etc. In such cases, the hospital will submit the Member's claims to the service center to begin claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to receive reimbursement for Covered Services. **The Member must contact the Claims Administrator to obtain precertification for non-emergency inpatient services.**

➤ Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require the Member to pay in full at the time of service. The Member must submit a claim to obtain reimbursement for Covered Services.

SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION

Precertification Review

When required, Precertification review 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 planned or elective Inpatient Admissions and selected Outpatient procedures. Precertification review may be initiated by the Provider (for Participating Providers and BlueCard Providers (Inpatient Admissions only)) or the Member. Where Precertification review is required, the Claims Administrator's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for Medical Necessity 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 review is not required for Emergency services.

▪ Inpatient Pre-Admission Review

In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Claims Administrator as to the Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this **General Information** section. The Member is responsible to contact or have the admitting Physician or other Facility Provider contact the Claims Administrator prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Claims Administrator will notify the Member, admitting Physician and the Facility Provider of the determination. The Member is eligible for Inpatient benefits only if prior approval of such benefits has been certified in accordance with the provisions of this Benefit Booklet.

If such prior approval for a Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown below, will be deemed not to be Covered Services under this Program. Such Penalty, and any difference in what is covered by the Claims Administrator and the Member's obligation to the Provider, will be the sole responsibility of, and payable by, the Member.

If a Member elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Member will be financially liable for non-covered Inpatient charges.

If pre-admission certification is denied, the Member, the Physician or the Facility Provider may Appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Member, Physician, or Facility Provider will be so notified.

The Claims Administrator will hold the Member harmless and the Member will not be financially responsible for admissions to Participating Hospitals which fail to conform to the above pre-admission certification requirements unless:

- The Hospital provides prior written notice that the admission will not be paid by the Claims Administrator; and
- The Member acknowledges this fact in writing together with a request to be admitted which states that the Member will assume financial liability for such Hospital admission.

▪ Emergency Admission Review

Members are responsible for notifying the Claims Administrator of an Emergency admission within two business days of the admission, or as soon as reasonably possible, as determined by the Health Benefit Plan.

Failure to initiate Emergency admission review will result in a reduction in Covered Expense. Such Penalty, as shown below, will be the sole responsibility of, and payable by, the Member.

If the Member elects to remain hospitalized after the Claims Administrator and the attending Physician have determined that an Inpatient level of care is not Medically Necessary, the Member will be financially liable for non-covered Inpatient charges from the date of notification.

▪ Concurrent and Retrospective Review

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay 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/Post Service review:

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Claims Administrator not being notified of a Member's admission until after discharge or where medical charts are unavailable at the time of concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, the Claims Administrator also may determine coverage of certain procedures and other benefits available to Members through Prenotification as required by the Member's benefit plan, and discharge planning.

Pre-notification. Pre-notification is advance notification to the Claims Administrator of an Inpatient Admission or Outpatient service where no Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Members for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Members 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 benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Claims Administrator's authorization of covered post-Hospital services and identifying and referring Members to Disease Management or Case Management benefits.

Selective Medical Review. In addition to the foregoing requirements, the Claims Administrator 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 Claims Administrator reserves the right to waive medical review for certain Covered Services for certain Providers, if the Claims Administrator determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services. Coverage penalties are not applied to Members where required Selective Medical Review is not obtained by the Provider.

Other Precertification Requirements

Precertification is required by the Claims Administrator in advance for certain services. **To obtain a list of services that require Precertification, please log on to www.ibxpress.com or call the Customer Service telephone number that is listed on the Member's Identification Card.** When a Member plans to receive any of these listed procedures, the Claims Administrator will review the Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed on the Precertification requirements list, that are performed during an Emergency, as determined by the Claims Administrator, do not require Precertification. However, the Claims Administrator should be notified within two business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Claims Administrator.

The Member is responsible to have the Provider performing the service contact the Claims Administrator to initiate Precertification for Non-Participating Providers and BlueCard Providers (excluding Inpatient Admissions). The Claims Administrator will verify the results of the Precertification with the Member and the Provider.

If such prior approval is not obtained and the Member undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance or Deductibles shall be subject to a Penalty, as reflected below. Such Penalty, and any difference in what is covered by the Claims Administrator and the Member's obligation to the Provider, will be the sole responsibility of, and payable by, the Member.

Precertification Penalty:

There is a \$700 Penalty for failure to preauthorize Inpatient services or treatment, and a 20% reduction in benefits for failure to preauthorize Outpatient services or treatment.

Remember: services that are not determined by the Claims Administrator to be Medically Necessary may not be paid.

Disease Management and Decision Support Programs

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 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 Physicians. Decision Support also includes the availability of general health information, personal health coaching, Provider 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 Physician(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 Claims Administrator will utilize medical information such as claims data to operate the Disease Management or Decision Support program, (For example, to identify Members with chronic disease, to predict which Members would most likely benefit from these services, and to communicate results to the Member's treating Physician(s)). The Claims Administrator 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 Claims Administrator that they have declined participation;
- The Claims Administrator determines that the program, or aspects of the program, will not continue;or
- The Member's Employer decides not to offer the programs.

UTILIZATION REVIEW PROCESS AND CRITERIA

Utilization Review Process

A basic condition of IBC's, and its subsidiary QCC Insurance Company's ("Claims Administrator") benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Necessary. To assist the Claims Administrator in making coverage determinations for requested health care services, the Claims Administrator uses established IBC 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 Claims Administrator 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 has been approved by the Claims Administrator 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 it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Claims Administrator 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 coverage approval using the Claims Administrator's Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Claims Administrator 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 are 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 the Claims Administrator's Medical Directors to discuss coverage of a case. 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 Claims Administrator 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.

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 is an externally validated and computer-based system used to assist the Claims Administrator in determining Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff evaluating the Medical Necessity of coverage based on a Member's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Claims Administrator's plan determinations for similar medical issues and requests, and reduces practice variation among the Claims Administrator'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 hospitalizations
- Inpatient Rehabilitation
- Home Health
- Durable Medical Equipment
- Skilled Nursing Facility

Centers for Medicare and Medicaid Services (CMS) Guidelines: A set of guidelines adopted and published by CMS for coverage of services by Medicare for Medicare Members.

IBC Medical Policies: IBC maintains an internally developed set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which IBC's Medical Polices are applied include, but are not limited to:

- Ambulance;
- Infusion;
- Speech Therapy;
- Occupational Therapy;
- Durable Medical Equipment;
- Review of potential cosmetic procedures

IBC (and QCC) Internally Developed Guidelines: A set of guidelines developed specifically by IBC (and QCC), as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting IBC Medical Policies for coverage.

Delegation of Utilization Review Activities And Criteria

In certain instances, the Health Benefit Plan has delegated certain utilization review activities, including Precertification review, 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 type of benefit or service (such as mental health/psychiatric care and Alcohol and Drug Abuse 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 Claims Administrator's approval.

Utilization Review and Criteria for Mental Health/Psychiatric Care and Alcohol and Drug Abuse Services

Utilization Review activities for mental health/psychiatric care and Alcohol and Drug Abuse services have been delegated by IBC (and QCC) to a behavioral health management company, which administers the mental health/psychiatric care and Alcohol and Drug Abuse benefits for the majority of the Claims Administrator's Members.

COORDINATION OF BENEFITS

Coordination of Benefits

This Program's Coordination of Benefits (COB) provision is designed to conserve funds associated with health care.

▪ Definitions

In addition to the Definitions of this Program for purposes of this provision only:

"Plan" shall mean any group arrangement providing health care benefits or Covered Services through:

- Individual, group, (except hospital indemnity plans), blanket (except student accident) or franchise insurance coverage;
- The Plan, health maintenance organization and other prepayment coverage;
- Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
- Coverage under any tax supported or government program to the extent permitted by law.

▪ Determination of Benefits

COB applies when an Employee has health care coverage under any other group health care plan (Plan) for services covered under this Program, or when the Employee has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between the Claims Administrator and the other Plan in order to avoid duplication of benefits.

Benefits under this Program will be provided in full when the Claims Administrator is primary, that is, when the Claims Administrator determines benefits first. If another Plan is primary, the Claims Administrator will provide benefits as described below.

When an Employee has group health care coverage under this Program and another Plan, the following will apply to determine which coverage is primary:

- If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.
- If the other Plan includes rules for coordinating benefits:

- The Plan covering the patient other than as a Dependent shall be primary.
- The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary.
- Except as provided in the following paragraph, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
 - ❖ First, the Plan covering the child as a Dependent of the parent with custody;
 - ❖ Then, the Plan of the spouse of the parent with custody of the child;
 - ❖ Finally, the Plan of the parent not having custody of the child.
- When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in the paragraph that begins "The Plan covering the patient as a Dependent".
- The Plan covering the patient as an Employee who is neither laid off nor retired (or as that Employee's Dependent) is primary to a Plan which covers that patient as a laid off or retired Employee (or as that Employee's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
- If none of the above rules apply, the Plan which covered the Employee longer shall be primary.

▪ Effect on Benefits

When the Claims Administrator's Plan is secondary, the benefits under this Program will be reduced so that the Claims Administrator will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Program and the total Covered Services provided to the Employee. Benefits payable under another Plan include benefits that would have been payable had the claim been duly made therefore. In no event will the Claims Administrator payment exceed the amount that would have been payable under this Program if the Health Benefit Plan were primary.

When the benefits are reduced under the primary Plan because an Employee does not comply with the Plan provision, or does not maximize benefits available under the primary Plan, the amount of such reduction will not be considered an allowable benefit. Examples of such provisions are Participating Provider arrangements and other cost-sharing features.

Certain facts are needed to apply COB. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Claims Administrator deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Claims Administrator such information as may be necessary to implement this provision. The Claims Administrator, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Program shall be affected by the benefits that would be payable under any and all other Plans only to the extent that the Claims Administrator is furnished with information relative to such other Plans.

▪ Right of Recovery

Whenever payments which should have been made under this Program in accordance with this provision have been made under any other Plan, the Claims Administrator shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits provided under this Program and, to the extent of such payments, the Claims Administrator shall be fully discharged from liability under this Program.

Whenever payments have been made by the Claims Administrator in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Claims Administrator shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Claims Administrator shall determine:

- The person the Claims Administrator has paid or for whom they have paid;
- Insurance companies; or
- Any other organizations.

The Member, on the Member's own behalf and on behalf of the Member's Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to the Claims Administrator.

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, the Member agrees that the Claims Administrator has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Claims Administrator or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

Subrogation Rights

Subrogation rights arise when the Claims Administrator pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Claims Administrator is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Claims Administrator "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Claims Administrator has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Claims Administrator for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The Claims Administrator has a right to full reimbursement.

Lien

By accepting benefits for Covered Services from the Claims Administrator, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Claims Administrator the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Claims Administrator to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Claims Administrator has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Claims Administrator is reimbursed in full.

Constructive Trust

If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Claims Administrator has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Claims Administrator to the full extent that the Claims Administrator has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Claims Administrator.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Claims Administrator is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Claims Administrator to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Claims Administrator will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Claims Administrator will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Claims Administrator agrees to do so in writing. The recovery rights of the Claims Administrator will not be reduced by the "common fund" doctrine.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Claims Administrator will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Claims Administrator is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Claims Administrator or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Claims Administrator or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Claims Administrator or its delegated representative.
- Fully cooperate with the Claims Administrator and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply

information/documentation when requested and promptly execute any and all forms/documents that may be needed.

- Avoid taking any action that may prejudice or harm the Claims Administrator ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Claims Administrator or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Claims Administrator paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

IMPORTANT: Failure to Cooperate

If the Member fails or refuses to sign forms or documents as requested or otherwise fail or refuse to cooperate or abide by any of the obligations described above, the Claims Administrator or Plan Administrator, as applicable, has full discretion and authority to reduce or withhold benefit payments to recover subrogation/reimbursement amounts that are owed and/or to terminate the Member's participation in the Program.

CLAIM PROCEDURES

How To File A Claim

When the Member needs to file a claim, the Member should fill out the claim form and return it with their itemized bills to the Claims Administrator no later than 90 days after completion of the Covered Services. The claim should include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 90-day period, the Member's benefits will not be reduced, but in no event will the Claims Administrator be required to accept the claim more than 12 months after the end of the Benefit Period in which the Covered Services are rendered except in the absence of legal capacity of the claimant.

Release Of Information

Each Member agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Program may furnish to the Claims Administrator, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request.

The Claims Administrator may furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Claims Administrator needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Member who is unable to provide it, the Claims Administrator will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Member.

Limitation Of Actions

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than three years after the date Covered Services are rendered.

Claim Forms

The Claims Administrator will furnish to the Member or to the Group, for delivery to the Member, such claim forms as are required for filing proof of loss for Covered Services provided by Non-Participating Providers.

Timely Filing

The Claims Administrator will not be liable under this Program unless proper notice is furnished to the Claims Administrator that Covered Services have been rendered to a Member. Written notice must be given within 90 days after completion of the Covered Services. The notice must include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Claims Administrator within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Claims Administrator be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

Time of Payment of Claims

Claim payments for benefits payable under this Program will be processed immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all benefits for loss for which this Program provides periodic benefits will be paid not more than 30 days after receipt of proof of loss and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

If any indemnity of this Program shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, the Claims Administrator may pay such indemnity, up to an amount not exceeding \$1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by Claims Administrator to be equitably entitled thereto. Any payment made by the Claims Administrator in good faith pursuant to this provision shall fully discharge the Claims Administrator to the extent of such payment.

Physical Examinations and Autopsy

The Claims Administrator at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under this Program; and the Claims Administrator shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

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 (For example, use of Participating Providers), or to the administration of this Program by the Claims Administrator, the Claims Administrator 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 as required by the Special Circumstances as

defined below.

The Claims Administrator shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Claims Administrator nor the Participating Providers 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 Claims Administrator and appropriate regulatory authority, are extraordinary circumstances not within the control of the Claims Administrator, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot; or
- Civil insurrection.

COMPLAINT AND APPEAL PROCESS

Refer to the Keystone Member Benefit Booklet for a description of appeal procedures.

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.

Acupuncture

A therapeutic procedure performed by the insertion of one or more specially manufactured solid metallic needles into a specific location(s) on the body. The intent is to stimulate Acupuncture points, with or without subsequent manual manipulation.

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.

Alternative Therapies/Complementary Medicine

Complementary and alternative medicine, is defined as a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine based on recognition by the National Institutes of Health.

Ambulatory Surgical Facility

A facility operated, licensed or approved as an Ambulatory Surgical Facility by the responsible state agency, which provides specialty or multispecialty Outpatient surgical treatment or procedure that is not located on the premises of 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
- Has been approved by the Claims Administrator.

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.

Applicant And Employee/Member

You, the Employee who applies for coverage under the Program.

Application And Application Card

The request of the Applicant for coverage:

- Either written or via electronic transfer; and
- Set forth in a format approved by the Claims Administrator.

Attention Deficit Disorder

A disease that makes a person have a hard time paying attention; be too impulsive; and be overly active.

Autism Service Provider

A person, entity or group that provides treatment of Autism Spectrum Disorders (ASD), using an ASD Treatment Plan, and that is either:

- Licensed or certified in this Commonwealth; or
- Enrolled in the Commonwealth's medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law.

An Autism Service Provider shall include a Behavioral Specialist.

Autism Spectrum Disorders (ASD)

Any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor.

Autism Spectrum Disorders Treatment Plan (ASD Treatment Plan)

A plan for the treatment of Autism Spectrum Disorders:

- Developed by: A licensed Physician or licensed Psychologist who is a Professional Provider; and
- Based on: A comprehensive evaluation or reevaluation, performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

Behavioral Specialist

An individual with appropriate certification or licensure by the applicable state, who designs, implements or evaluates a behavior modification intervention component of an ASD (Autism Spectrum Disorder) Treatment Plan, through Applied Behavioral Analysis which includes:

- Skill acquisition and reduction of problematic behavior;
- Improve function and/or behavior significantly; or
- Prevent loss of attained skill or function.

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 Claims Administrator. 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 Claims Administrator 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 allows a Member to receive coverage for services at an in-network benefit level if the Member receives services from Blue Cross Blue Shield providers that participate in the BlueCard Program.

BlueCard Provider

A Provider that participates in the BlueCard Program.

Care Coordinator Fee

A fixed amount paid by a /Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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 entrestomal 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 Rehabilitation Therapy

Cognitive rehabilitation is 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 Covered Expense for Covered Services (such as 20%). The Coinsurance percentage is listed in the ***Schedule of Covered Services***.

It is the amount that the Member is obliged to pay for covered medical services, after the Member has satisfied any Copayment(s) or Deductible(s) required by this Program.

Compendia

Compendia are reference documents used by the Claims Administrator 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 Claims Administrator only reviews current Compendia when making coverage decisions.

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.

Consumable Medical Supply

Non-durable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not useful to a person in the absence of illness or injury.

Copayment

A type of cost-sharing in which the Member pays a flat dollar amount each time a Covered Service is provided (such as a \$10 or \$15 Copayment per office visit). Copayments, if any, are identified in the ***Schedule of Covered Services***.

Covered Expense

Refers to the basis on which a Member's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

- For Covered Services provided by a Facility Provider, the term "Covered Expense" means the following:
 - For Covered Services provided by a Participating Facility or BlueCard Provider, "Covered Expense" for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with the Claims Administrator or the BlueCard Provider.
 - For Covered Services provided by a Participating Facility or BlueCard Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with the Claims Administrator or the BlueCard Provider.

- For Covered Services provided by a Non-Participating Facility Provider, not successfully negotiated through the Price Protection Program, "Covered Expense" for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Facility Provider's charges for Covered Services.
- For Covered Services provided by a Non-Participating Facility Provider, not successfully negotiated through the Price Protection Program, "Covered Expense" for Inpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator's applicable proprietary fee schedule, the amount is determined by the applicable Claims Administrator's proprietary fee schedule for the closest analogous Covered Service.
- For Covered Services provided by a Professional Provider, "Covered Expense" means the following:
 - For Covered Services by a Participating Professional Provider or BlueCard Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with the Claims Administrator, or the BlueCard Provider.
 - For a Non-Participating Professional Provider, not successfully negotiated through the Price Protection Program, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or of the Provider's charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Professional Provider's charges for Covered Services.
- For Covered Services provided by an Ancillary Service Provider, "Covered Expense" means the following:
 - For Covered Services provided by a Participating Ancillary Service Provider or BlueCard Provider "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Claims Administrator or BlueCard Provider.
 - For Covered Services provided by a Non-Participating Ancillary Service Provider, not successfully negotiated through the Price Protection Program, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Non-Participating Ancillary Service Provider's charges for Covered Services.

- Nothing in this section shall be construed to mean that the Claims Administrator would provide coverage for services other than Covered Services.

Covered Service

A service or supply specified in this Benefit Booklet for which benefits will be provided by the Claims Administrator.

Custodial Care (Domiciliary Care)

Care provided primarily for Maintenance of the patient or care which is designed essentially:

- To assist the patient in meeting their 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 Provider's treatment plan. Some examples of support services are:

The Member returns home:

- Major treatment choices; and
- Every day health choices.

Deductible

A specified amount of Covered Expense for the Covered Services that is Incurred, by the Member, before the Claims Administrator will assume any liability.

- A specific dollar amount that the Member's Claims Administrator may require that the Member pay out-of-pocket each Benefit Period, before the Program begins to make payments for claims.

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 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)

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 Claims Administrator reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

Durable Medical Equipment (DME)

Equipment that meets the following criteria:

- It is durable. (That is, an item that can withstand repeated use.)
- It is medical equipment. (That 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 Claims Administrator.

Emergency

The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in 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 Member's health, or in the case of a pregnant Member, the health of the unborn child, in jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Care

Covered Services and supplies provided to a Member in, or for, an Emergency:

- By a Hospital or Facility Provider and/or Professional Provider; and
- On an Outpatient basis; and
- In a Hospital Emergency Room or Outpatient Emergency Facility.

Employee

An individual of the Group contracting with the Claims Administrator and:

- Who meets the eligibility requirements for enrollment; and
- Who, at enrollment, is specified as meeting the eligibility requirements; and
- In whose name the Identification Card is issued.

Equipment For Safety

Equipment used to keep people safe.

These are:

- Items that are not primarily used for the diagnosis, care or treatment of disease or injury.
- Items which are primarily used to prevent injury or provide a safe surrounding.

Examples include:

- Restraints;
- Safety straps;
- Safety enclosures; and
- Car seats.

Experimental/Investigative Services

A drug, biological product, device, medical treatment or procedure, or diagnostic test which meets any of the following criteria:

- Is the subject of: Ongoing clinical trials;
- Is the research, experimental, study or investigational arm of an ongoing 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.

Any drug, biological product, device, medical treatment or procedure, or diagnostic test is not considered Experimental/Investigative if it meets all of the criteria listed below:

- When required, the drug, biological product, device, medical treatment or procedure, or diagnostic test must have final approval from the appropriate governmental regulatory bodies (For example, FDA).
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.

- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test leads to measurable improvement in health outcomes (That is, the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test 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 in the previous bullet, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure or diagnostic test 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.

Any 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 a drug or biological product (For example, infusible agent) for another diagnosis or condition shall require that one or more of the established reference Compendia identified in the Claims Administrator policies recognize the usage as appropriate medical treatment.

Facility Provider

An institution or entity licensed, where required, to provide care.

- | | |
|---|-----------------------------------|
| ▪ Ambulatory Surgical Facility; | ▪ Non-Hospital Facility; |
| ▪ Birth Center; | ▪ Psychiatric Hospital; |
| ▪ Free Standing Dialysis Facility; | ▪ Rehabilitation Hospital; |
| ▪ Free Standing Ambulatory Care Facility; | ▪ Residential Treatment Facility; |
| ▪ Home Health Care Agency; | ▪ Short Procedure Unit; |
| ▪ Hospice; | ▪ Skilled Nursing Facility. |
| ▪ Hospital; | |

Family Coverage

Coverage purchased for the Member and one or more of the Member's Dependents.

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 Claims Administrator.

Group or (Enrolled Group)

A group of Employees which has been accepted by the Claims Administrator, consisting of all those Applicants whose charges are remitted by the Applicant's Agent together with all the Employees, listed on the Application Cards or amendments thereof, who have been accepted by the Claims Administrator.

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.

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 shown above:

- A child;
- An unlicensed driver; or
- An individual who cannot drive.

Home Health Care Provider

A Facility Provider, approved by the Claims Administrator, that is engaged in providing, either directly or through an arrangement, health care services to Members:

- On an intermittent basis in the Member's Home.
- In accordance with an approved home health care Plan Of Treatment.

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.

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 Claims Administrator, 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;
 - Nursing home;
 - School;
 - Custodial Care home
 - Health resort
 - Spa or sanitarium;
 - Place for rest;
 - Place for treatment of Alcohol or Drug Abuse;;
 - Place for provision of rehabilitation care;
 - Place for treatment of pulmonary tuberculosis;
 - Place for provision of Hospice Care.

- Place for aged;
- Place for treatment of Mental Illness;

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 Claims Administrator.

When these Physicians provide services other than in the Hospital or other Participating Facility, they are not considered Hospital-Based Providers.

Identification Card (ID Card)

The currently effective card issued to the Member by the Claims Administrator which must be presented when a Covered Service is requested.

Immediate Family

The Employee's:

- Spouse;
- Parent;
- Child, stepchild;
- Brother, sister; or
- Persons who ordinarily reside in the household of the Member

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 For Alcohol Or Drug Abuse And Dependency

The provision of medical, nursing, counseling or therapeutic services 24 hours a day in a Hospital or Non-Hospital Facility, according to individualized treatment plans.

Licensed Clinical Social Worker

A social worker who:

- 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 Disease Or Condition (for Qualifying Clinical Trials)

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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.

Master's 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/Psychiatric Services (including treatment of Serious Mental Illness).

Maximum

A limit on the amount of Covered Services that a Member may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance and Copayment amounts paid by Members for the Covered Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Claims Administrator to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

- Benefit Maximum - the greatest amount of a specific Covered Service that a Member may receive.
- Lifetime Maximum - the greatest amount of Covered Services that a Member may receive in the Member's lifetime.

Medical Care

Services rendered by a Professional Provider for the treatment of an illness or injury. These are services that must be rendered within the scope of their license.

Medical Foods

Liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

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; and
 - The views of Physicians practicing in relevant clinical areas; and
 - Any other relevant factors.

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.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Allowable Payment for Facilities

The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

Medicare Ancillary Allowable Payment

The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Service Provider.

Medicare Professional Allowable Payment

The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule - Pennsylvania Locality 01.

Member

An enrolled Employee or their Eligible Dependent(s) who have satisfied the specifications of the **General Information** section.

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 or Autism Spectrum Disorders.
- The benefit limits for Mental Illness, Serious Mental Illness, and Autism Spectrum Disorders are separate and not cumulative.

Methadone Treatment

Provision and supervision of methadone hydrochloride in prescribed doses for the treatment of opioid dependency.

Naturally Slim®

A clinical behavioral weight loss program, using informative videos and learning tools to teach the Member how to lose weight and improve the Member's health. The on-line program is available via the Member's:

- Desktop;
- Laptop; or
- Mobile device.

Negotiated Arrangement a.k.a., Negotiated National Account Arrangement

An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

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-Hospital Residential Treatment

The provision of medical, nursing, counseling, or therapeutic services to Members diagnosed with Alcohol Or Drug Abuse And Dependency:

- In a residential environment;
- According to individualized treatment plans.

Non-Participating Ancillary Service Provider

An Ancillary Service Provider that has not agreed to a rate of reimbursement determined by contract with the Claims Administrator for the provisions of Covered Services to Members.

Non-Participating Facility Provider

A Facility Provider that has not agreed to a rate of reimbursement determined by contract with the Claims Administrator for the provisions of Covered Services to Members.

Non-Participating Mail Order Pharmacy

A Mail Order Pharmacy that has not agreed to a rate of reimbursement determined by contract with the Claims Administrator.

Non-Participating Pharmacy

A Pharmacy that has not agreed to a rate of reimbursement determined by contract with the Claims Administrator.

Non-Participating Professional Provider

A Professional Provider who has not agreed to a rate of reimbursement determined by contract with the Claims Administrator for the provisions of Covered Services to Members.

Non-Participating Provider

A Facility Provider, Professional Provider, Ancillary Service Provider or Pharmacy that does not have a contractual relationship with the Claims Administrator for the provisions of Covered Services to Members.

Nutritional Formula

Liquid nutritional products which are formulated to supplement or replace normal food products.

Out-of-Pocket Limit

A specified dollar amount of Coinsurance expense Incurred by the Member for Covered Services in a Benefit Period.

- Such expense does not include any Deductible, Penalties or Copayment amounts.
- When the Out-of-Pocket Limit is reached, the level of benefits is increased, as specified in the ***Schedule of Covered Services***.

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 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.

Partial Hospitalization

Medical, nursing, counseling or therapeutic services that are:

- Provided on a planned and regularly scheduled basis in a Hospital or Facility Provider; and
- 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 Ancillary Service Provider

An Ancillary Service Provider that has agreed to a rate of reimbursement determined by a contract with the Claims Administrator for the provision of Covered Services to Members.

Participating Facility Provider

A Facility Provider that has agreed to a rate of reimbursement determined by a contract with the Claims Administrator for the provision of Covered Services to Members.

Participating Mail Order Pharmacy

A Pharmacy that has agreed to a rate of reimbursement determined by a contract with the Claims Administrator to provide Members with mail order prescription drug services.

Participating Pharmacy

A Pharmacy that has agreed to a rate of reimbursement determined by a contract with the Claims Administrator for Prescription Drugs provided to Members.

Participating Professional Provider

A Professional Provider who has agreed to a rate of reimbursement determined by a contract with the Claims Administrator for the provision of Covered Services to Members.

Participating Provider

A Facility Provider, Professional Provider, Ancillary Service Provider or Pharmacy that has agreed to a rate of reimbursement determined by a contract with the Claims Administrator for the provision of Covered Services to Members.

Penalty

A type of cost-sharing in which the Member is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified and explained in detail in the **General Information** section.

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.

Physician

A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), 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.

Precertification (or Precertify)

Prior assessment by the Claims Administrator or a designated agent that proposed services, such as hospitalization, are Medically Necessary for a Member and covered by this Program. Payment for services depends on whether the Member and the category of service are covered under this Program.

Prenotification (Prenotify)

The requirement that a Member provide prior notice to the Claims Administrator 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.

Preventive Care

Means:

- Evidence-based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the Member;

- Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;
- Evidence-informed preventive care and screenings for Members who are infants, children, and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Evidence-informed preventive care and screenings for Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Any other evidence-based or evidence-informed items as determined by the federal and/or state law.

Examples of Preventive Care include, but are not limited to:

- Routine physical examinations, including related laboratory tests and X-rays;
- Immunizations and vaccines;
- Well-baby care;
- Pap smears;
- Mammography;
- Screening tests, including colorectal cancer and prostate cancer screenings; and
- Bone density tests.

Price Protection Program

Program in which the Claims Administrator, or its vendor, will negotiate Out-of-Network claims with the Out-of-Network Provider to attempt to obtain a discount from billed charges and hold the Member harmless from Provider balance billing. When the Out-of-Network Provider agrees to a negotiated amount (referred to as a “successfully negotiated claim”), the Claims Administrator will reimburse the Out-of-Network Provider directly and the Member shall be responsible for any Member cost sharing. If the Out-of-Network Provider does not agree to a negotiated amount, the claim reimbursement will be governed by the Covered Expense definition.

- **The Price Protection Program applies to** Out-of-Network Provider charges at an invoiced amount determined by the Claims Administrator from Out-of-Network Providers outside of the following Pennsylvania counties:
 - Bucks
 - Chester
 - Delaware
 - Montgomery; and
 - Philadelphia.
- **The Price Protection Program does not apply to:**
 - Claims when the Member has not satisfied the Out-of-Network Deductible in full;
 - Claims originating outside of the United States;
 - Drug and Alcohol claims;
 - Medicare claims;
 - Coordination of Benefits claims;
 - Claims that have already been successfully negotiated or adjusted.

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 with an unrestricted, unsanctioned license, who is licensed, where required, and performing services within the scope of such licensure. The Professional Providers are:

- Audiologist;
- Autism Service Provider;
- Behavior Specialist;
- Certified Registered Nurse
- Master's Prepared Therapist;
- Nurse Midwife;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- Chiropractor;
- Dentist;
- Independent Clinical Laboratory;
- Licensed Clinical Social Worker;
- 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 Claims Administrator.

Prosthetics (or Prosthetic Devices)

Devices (except dental Prosthetics), 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

A Facility Provider, Professional Provider or Ancillary Service Provider, licensed where required.

Provider Incentive

An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group/population of Members.

Psychiatric Hospital

A Facility Provider, approved by the Claims Administrator, 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 they practice; 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 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 Claims Administrator as a Qualifying Clinical Trial.

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 Claims Administrator, 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.

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 Claims Administrator, 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.

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.

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 with a syringe and needle; and
- 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.

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 Statistical 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 Provider.

Covered Services may be provided on an Outpatient or Inpatient basis.

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 Claims Administrator 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 Claims Administrator.

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.

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 Professional 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 Professional Provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.

The Claims Administrator reserves the right to determine which Specialty Drug vendors and/or Professional 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 Claims Administrator to be a Self-Administered Prescription Drug or a Specialty Drug. Instead, these drugs need to be administered by a Professional Provider.

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 Professional Provider.

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

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 patient's tolerance for physical activity or exercise.
- Chemotherapy
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells.
- 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 Professional 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 Professional 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 Claims Administrator.

- 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.

- Orthoptic/Pleoptic Therapy
Medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception.

Such dysfunction results from:

- Vision disorder;
- Eye Surgery; or
- Injury.

Treatment involves a program which includes evaluation and training sessions.

- 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:

<ul style="list-style-type: none"> ➤ Posture; ➤ Mobility; ➤ Strength; ➤ Endurance; ➤ Balance; 	<ul style="list-style-type: none"> ➤ Coordination; ➤ Joint Mobility; ➤ Flexibility; and ➤ The functional activities of daily living.
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- 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.

- Radiation Therapy
The treatment of disease by:
 - X-Ray;
 - Gamma ray;
 - Accelerated particles;
 - Mesons; or
 - Neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.

- Speech Therapy
Medically prescribed services that are necessary for the diagnosis and/or treatment of speech and language disorders, due to conditions or events that result in communication disabilities and/or swallowing disorders:
 - Disease;
 - Surgery;
 - Injury;
 - Congenital and developmental anomalies (birth defects); or
 - Previous therapeutic processes.

Total Disability (or Totally Disabled)

Means that a Covered Employee who, due to illness or injury:

- Cannot perform any duty of their occupation or any occupation for which the Employee is, or may be, suited by education, training and experience; and
- Is not, in fact, engaged in any occupation for wage or profit.

A Dependent is totally disabled if: They cannot engage in the normal activities of a person in good health and of like age and sex.

The Totally Disabled person must be under the regular care of a Physician.

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 your Professional Provider is unavailable. Examples of Urgent Care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not Preventive Care.

Urgent Care Centers

Facility Provider designed to offer immediate evaluation and treatment for sudden health conditions and accidental injuries that:

- Require medical attention in a non-Emergency situation; and
- When the Member's Professional Provider's office is unavailable.

Urgent Care is not the same as: Emergency Services (see definition of "Urgent Care" above).

Value-Based Program (VBP)

An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

IMPORTANT NOTICES

Regarding Experimental/Investigative Treatment:

The Claims Administrator does not cover treatment it determines to be Experimental/Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Claims Administrator acknowledges that situations exist when a Member and their Physician agree to utilize Experimental/Investigative treatment. If a Member receives Experimental/Investigative treatment, the Member shall be responsible for the cost of the treatment. A Member or their Physician should contact the Claims Administrator to determine whether a treatment is considered Experimental/Investigative. The term "Experimental/Investigative" is defined in the ***Important Definitions*** section.

Regarding Treatment Which Is Not Medically Necessary:

The Claims Administrator only covers treatment which it determines Medically Necessary. A Participating Provider accepts the Claims Administrator's decision and contractually is not permitted to bill the Member for treatment which the Claims Administrator determines is not Medically Necessary unless the Participating Provider specifically advises the Member in writing, and the Member agrees in writing that such services are not covered by the Claims Administrator, and that the Member will be financially responsible for such services. A Non-Participating Provider, however, is not obligated to accept the Claims Administrator's determination and the Member may not be reimbursed for treatment which the Claims Administrator determines is not Medically Necessary. The Member is responsible for these charges when treatment is received by a Non-Participating Provider. The Member can avoid these charges simply by choosing a Participating Provider for the Member's care. The term "Medically Necessary" is defined in the ***Important Definitions*** section.

Regarding Treatment for Cosmetic Purposes:

The Claims Administrator does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Claims Administrator acknowledges that situations exist when a Member and their Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Member is responsible for the cost of the treatment. A Member or their Physician should contact the Claims Administrator to determine whether treatment is for cosmetic purposes. The exclusion for services and operations for cosmetic purposes is detailed in the ***Exclusions - What Is Not Covered*** section.

Regarding Coverage for Emerging Technology:

While the Claims Administrator does not cover treatment it determines to be Experimental/Investigative, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Claims Administrator uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Member, the Claims Administrator researches all scientific information available from these expert sources. Following this analysis, the Claims Administrator 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 for the condition being treated or not approved as required by federal or governmental agencies. A Member or their Provider should contact the Claims Administrator to determine whether a proposed treatment is considered "emerging technology" and whether the Provider is considered an eligible Provider to perform the "emerging technology" Covered Service. The Claims Administrator maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

Regarding Non-Discrimination Rights

The Member has the right to receive health care services without discrimination:

- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Discretionary Authority

The Claims Administrator or Plan Administrator, as applicable, retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this Program will be provided only if the Claims Administrator or Plan Administrator, as applicable, determines in its discretion that the Member is entitled to them.

REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of "Experimental/Investigative", "cosmetic", or "emerging technology", the Member, or their Provider, should contact the Claims Administrator for a coverage determination. That way the Member and the Provider will know in advance if the treatment will be covered by the Claims Administrator.

In the event the treatment is not covered by the Claims Administrator, the Member can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service.

For more information on when to contact the Claims Administrator for coverage determinations, please see the Precertification and Prenotification requirements in the *General Information* section.

RIGHTS AND RESPONSIBILITIES

To obtain a list of "Rights and Responsibilities", please log on to http://www.ibx.com/members/quality_management/member_rights.html or the Member should call the Customer Service telephone number that is listed on their Identification Card to receive a printed copy.