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Comprehensive Major Medical Program For

**TEMPLE UNIVERSITY
GRADUATE AND UNDERGRADUATE STUDENTS**

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SECTION 1

SCHEDULE OF BENEFITS

This is a summary of the benefits provided under your CompSelectsm Program through Temple University. **Please refer to Section 5, Covered Services, for more information on benefits, restrictions or limitations.**

Effective Date of coverage September 1, 1994: Coverage for students and eligible dependents eligible after the Effective Date will become effective on March 1 or September 1 of each year thereafter.

Benefit Period	Calendar Year (January through December)
Your Deductible	\$500 per person, per benefit period
Family Deductible (Aggregate)	\$1,000 per family, per benefit period
Co-insurance	75/25% (50/50% Outpatient Psychiatric Care and covered Diagnostic Services)
Your Out-of-Pocket Co-insurance Limit	\$3,000 per person, per benefit period (Excluding Psychiatric expenses)
Family Out-of-Pocket Co-insurance Limit (Aggregate)	\$6,000 per family, per benefit period (Excluding Psychiatric expenses)
Lifetime Maximum	\$1,000,000 per person
Reinstatement	\$1,000 is the amount that will be restored each Benefit Period to the Subscriber's Lifetime Maximum amount. However, the amount restored will not exceed the amount paid by the Plan for Covered Services rendered in the preceding Benefit Period.
Inpatient Psychiatric Care	Covered for 30 days per Benefit Period for Mental Illness.
Inpatient Care for Serious Mental Illness	Covered for 30 Days per Benefit Period for Serious Mental Illness. Each available day may be traded on a one (1) for two (2) basis for Partial Hospitalization/Outpatient facility/professional visits.

Outpatient Psychiatric Care Covered at 50%, limited to 30 visits per Benefit Period, with a maximum payment of \$35 per visit for Mental Illness.

Outpatient Care for Serious Mental Illness Maximum of 60 days per Benefit Period. Inpatient days may be exchanged for additional Outpatient days; each Inpatient day may be exchanged for two Outpatient Facility/Professional visits.

Pre-existing Conditions No exclusion

YOUR BENEFITS INCLUDE:

Hospitalization (70 days per benefit period) Inpatient services, room and board and ancillary services

Inpatient Medical Visits Covered at 75%

Surgery, including assistant surgeon, transplants, oral surgery Covered at 75%

Voluntary Second Surgical Opinion Not subject to deductible or coinsurance - Paid at 100% UCR

Anesthesia Covered at 75%

Outpatient Emergency Care Covered at 75%

Home and Office Visits Covered at 100% - \$10 copayment - limit 4 per individual, per calendar year. Not subject to deductible.

Pediatric Immunizations Covered at 75%; Not subject to deductible -

Routine Gynecological Examination and Papanicolaou Smear Not subject to deductible or coinsurance - Paid at 100% UCR

Mammography Covered

Medical Foods and Nutritional Formulas (Medical Foods are not subject to deductible) Covered at 75%

Diagnostic Services Covered at 50%

Allergy Testing Covered at 50% UCR

Chemotherapy, Radiation Therapy and Infusion Therapy Covered at 75%

Dialysis Treatment	Covered at 75% - however, if a Subscriber receives services in a non-member Free-Standing Dialysis Facility located in the Philadelphia five-county area, the benefits for such services will be reduced by 50%. Any deductible or coinsurance amounts will be applied after such reduction.
Physical, Cardiac and Respiratory Therapy	Covered at 75%, subject to a \$1,000 aggregate maximum per person, per benefit period when performed on an Outpatient basis
Occupational and Speech Therapy	Covered at 75% when performed on an inpatient basis. Outpatient benefits are not available.
Maternity and Newborn Care	Covered at 75%
Alcohol and Drug Abuse Treatment	Covered at 75%
Skilled Nursing Facility Care	30 Days per benefit period and 35 physician's visits per benefit period
Durable Medical Equipment, Orthotics, Prosthetics	Covered at 75% - requires pre-certification for items with a cost of \$1,500 or more
Home Health Care	Covered at 75%
Hospice Care	Covered at 75% Respite care covered up to 7 days every 6 months.
Diabetic Education Program	Covered at 100%; Not subject to deductible
Diabetic Equipment and Supplies	Covered at 75%
Blood	Covered at 75% after 2-pint deductible
Prescription Drugs	Not Covered, except for Insulin and Oral Agents.
Ambulance Service	Covered at 75%; Ground, air and sea transportation. Ground transportation: Maximum of \$250 per person, per benefit period.
Outpatient Private Duty Nursing	Covered at 75% - requires pre-certification after 100 hours

Day Rehabilitation Program

Covered at 75%; benefits are limited to 30 sessions per Benefit Period.

Managed Care Programs

Preadmission Certification

Included

Individual Case Management

Included

SECTION 2

GENERAL INFORMATION

WHO IS ELIGIBLE AND WHEN?

CompSelectsm benefits through **Temple University** are available to you, your spouse and all unmarried children under 19 years of age.

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 for over half of their support upon a Student covered under this Program. The Plan may require proof of such Subscriber's eligibility under the prior carrier's plan and also from time to time under this Program. Continuation of benefits under this provision will only apply if the child was eligible as a dependent prior to age 19.

WHAT ABOUT CHANGES IN MY ADDRESS OR FAMILY STATUS?

It is important that you notify your Benefits Department promptly of any change in your address or family status including marriage, divorce, birth or adoption of a child, marriage of dependent children, death of spouse or child. Please provide this information to your group benefits administrator as soon as possible.

Coverage of a dependent child will terminate as of the annual anniversary date following the date he or she reaches age 19.

If an overage child does not receive notice of termination, you should apply to the Plan within 60 days of the termination date for the individual coverage then available. If you pay the premium due for the individual coverage, beginning with the termination date of the group coverage, the Plan will establish an account for your dependent and will take previous coverage into consideration in determining length of membership.

Whenever any other dependent no longer qualifies as eligible to be included under your coverage, the same provision for conversion to an individual account will apply.

When you cease to be eligible for this program, your coverage will terminate at the end of the last month for which payment was made. However, if benefits under the Group Contract are provided by and/or approved by the Plan before the Plan receives notice of your termination under the Group Contract, the cost of such benefits will be your sole responsibility. In that circumstance, the Plan will consider the effective date of your termination under the Group Contract to be not more than 60 days before the first day of the month in which the Group notified the Plan of such termination.

HOW ARE CLAIMS PAID AND PROCESSED?

For Inpatient Hospital Care

When you or your eligible Dependents are admitted to an Independence Blue Cross Member Hospital, show your Identification Card to the admitting clerk and provide information as requested. Upon discharge, the Plan will pay the Hospital directly for your eligible services, excluding any Coinsurance and/or Deductible amounts. The Plan will then send you an explanation of benefits which includes the amount paid on your behalf. The Hospital will then collect any Coinsurance and/or Deductible amounts from you and any remaining expenses not paid for by the Plan.

If you use an approved Hospital outside of the Philadelphia five-county area, be sure to get an itemized bill, listing the name and address of the Hospital, the patient's name and age, the date of admission and your name and address. Forward this bill and a completed claim form to Highmark Blue Shield , CompSelectsm P. O. Box 890029, Camp Hill, PA 17089-0029, together with your Identification Number and the reason for hospitalization. Payment will be made directly to you for eligible services, less any Coinsurance and/or Deductible amounts. It is your responsibility to forward full payment to the Hospital.

For Outpatient Hospital Care

Services performed in a Member Hospital or any Approved Hospital outside of the Philadelphia five-county area will follow the same procedures as inpatient care, and for an accident, specify the date and hour of the accident.

For Participating Professional Providers

Present your Identification Card at the time services are provided by a Participating Professional Provider. The Professional Provider will submit a claim form directly to Blue Shield on your behalf. The payment will be sent to the Professional Provider and we will notify you of the final disposition of the claim. The Participating Professional Provider will bill you for any Coinsurance/Deductible amounts.

For Non-Participating Professional Providers

In most cases, a Non-Participating Professional Provider may also submit a claim to Blue Shield on your behalf. When services are performed by Non-Participating Professional Providers, the payment is made directly to you. You are responsible for the total charges made by the Non-Participating Professional Provider.

BlueCard Program

When you obtain health care services through BlueCard outside the geographic area Independence Blue Cross ("IBC") and Highmark Blue Shield ("HBS") serve, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Plan") passes on to us.

Often this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, IBC and HBS would then calculate your liability for any covered health care services in accordance with the applicable Host Blue state statute in effect at the time you received your care.

Consumer Rights

Each Covered Person 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 on your ID card.

WHY SHOULD I USE PARTICIPATING PROFESSIONAL PROVIDERS?

Participating Professional Providers will accept Blue Shield insurance allowances as payment for Covered Services. They cannot charge you beyond the allowances, except for Deductibles and Coinsurance that may apply. Of course, if you have reached the maximum benefit for a particular service, you would be responsible for those expenses. Non-participating Providers may charge you more.

The savings vary, depending on the doctor and the type of services provided. Over the course of a year, though, the savings can really add up.

Participating Professional Providers also make using your health coverage simpler. As an additional service, Participating Professional Providers handle all claims filing paperwork by submitting your claims directly to Blue Shield. All you do when you visit the doctor is show your Identification Card.

It's easy to find a Participating Professional Provider. They represent nearly every health care specialty, including:

- Family Physicians (Pediatricians, too)
- Osteopaths
- Chiropractors

- Psychologists
- Certified Nurse-Midwives
- Physical Therapists
- Podiatrists
- Optometrists
- Certified Registered Nurse
- Dentist
- Independent Clinical Laboratory
- Licensed audiologist
- Licensed speech-language pathologist
- Licensed teacher of the hearing impaired

Thus, there are Participating Professional Providers to meet the health care needs of you and your family. The best way to know if a Provider participates with Blue Shield is to call the Provider's office and ask before you receive services.

HOW DO I FILE CLAIMS?

For the times when it is necessary for you to submit a claim yourself, you must request an itemized bill which shows:

- (1) patient's name and address
- (2) date of service
- (3) type of service, diagnosis, and the procedure performed
- (4) itemized charges
- (5) Provider's complete name and address

Attach this bill to a claim form, being sure to complete all the information requested on the form. Please send your itemized bill and claim form to:

Highmark Blue Shield
CompSelectsm
P.O. Box 890029
Camp Hill, PA 17089-0029

If you need assistance, contact CompSelect Customer Service within Philadelphia at 215-567-3530 or outside Philadelphia at 1-800-562-7981.

Never send original bills without first copying them. Make sure all the required information, including the diagnosis, is on the bills. Missing information means delays in reimbursement to you. Claims for covered medical expenses must be filed no later than one year after the end of the Benefit Period in which the covered medical expenses were incurred. No payment will be made for claims received after the time limit.

WHAT HAPPENS TO MY MEDICAL COVERAGE IF I AM NO LONGER ELIGIBLE UNDER THIS PLAN?

If you cease to be eligible for benefits under this coverage because you are no longer a full-time student, you may be eligible for arrangements for Coverage under an individual contract available from the Plan.

Conversion coverage is available for your surviving spouse and child(ren) when appropriate.

Children who reach the maximum age limit specified in this booklet also have the privilege of converting to an individual contract.

If the Subscriber is an Inpatient on the day coverage terminates, the benefits of the Contract shall be provided:

1. Until the maximum amount of benefits has been paid; or
2. Until the Inpatient stay ends, whichever occurs first.

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, or to the procedures required for obtaining benefits for Covered Services under this Contract (e.g., obtaining Precertification, use of Member or Participating Providers), or to the administration of the Contract by the Plan, the Plan may on a selective basis, waive certain procedural requirements of this Contract. 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 Plan 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 Plan nor Member 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 Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Plan, including but not limited to: (a) major disaster (b) epidemic; (c) pandemic; (d) the complete or partial destruction of facilities; (e) riot; or (f) civil insurrection.

Release Of Information

Each Subscriber agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Contract may furnish to the Plan, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Plan may furnish similar information to other entities providing similar benefits at their request.

The Plan 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 Plan needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Subscriber who is unable to provide it, the Plan 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 Subscriber.

SECTION 3

YOUR COMPSELECTsm PLAN

INTRODUCTION

CompSelect is a comprehensive major medical plan that provides you and your family valuable protection against illness or injury.

Payments under this program, subject to any Deductibles or Maximums, will be made at an allowance determined by the Plan but not more than the charge for the services performed.

PLEASE REFER TO THE SCHEDULE OF BENEFITS IN SECTION 1 FOR SPECIFIC BENEFIT ALLOWANCES AND LIMITATIONS. ALSO, ADDITIONAL INFORMATION REGARDING YOUR BENEFITS MAY BE FOUND IN SECTION 5 AND IN SECTION 8 - DEFINITION OF TERMS.

In addition, the Plan will make the determination as to whether services or supplies rendered by a Provider meet the criteria of Medically Necessary and/or Medically Appropriate.

PAYMENT OF BENEFITS

Payment of Covered Services for Medically Necessary and/or Medically Appropriate services and supplies are subject to the following conditions provided during a Benefit Period.

IS A DEDUCTIBLE REQUIRED?

Yes. In each Benefit Period you pay a portion of your covered medical expenses before CompSelectSM begins to provide coverage. Expenses incurred for Covered Services in the last three (3) months of a Benefit Period which were applied to that Benefit Period's Deductible will be applied to the Deductible of the next Benefit Period.

For family coverage there is an aggregate family Deductible per Benefit Period. However, not more than one (1) Deductible can be contributed by any one family member.

DOES COMPSELECTsm HAVE COINSURANCE AMOUNTS?

Yes. After the Deductible has been paid, the CompSelectsm program pays a percentage for Covered Expenses.

IS THERE A LIMIT TO MY COINSURANCE LIABILITY?

Yes. There is a Maximum placed on the amount of Coinsurance for Covered Services which you are required to pay. This Maximum is called your "Out-of-Pocket" Limit.

When your Out-of-Pocket Limit is reached, or a family's Out-of-Pocket Limit is reached, CompSelect will pay 100% of any Provider's reasonable charge incurred during the balance of the Benefit Period. In meeting the family Out-of-Pocket Limit, no more than the individual

Out-of-Pocket Limit may be contributed by any one family member. PLEASE NOTE: Your Deductible and charges for psychiatric care do not count towards the Out-of-Pocket Limit.

ARE THERE LIFETIME MAXIMUM AMOUNT PAYMENTS UNDER MY PROGRAM?

Yes. As stated in your Schedule of Benefits, there is a Maximum amount of CompSelectsm benefits that may be provided during your lifetime and for each of your eligible Dependents.

IS THIS MAXIMUM RENEWABLE?

Yes. Under certain conditions a portion of your Lifetime Maximum may be renewed.

ARE THERE SPECIAL PROVISIONS FOR THE TREATMENT OF DRUG ADDICTION AND ALCOHOLISM?

Yes. Please refer to the description of benefits for Alcohol or Drug Abuse and Dependency in Section 5.

IN WHAT HOSPITALS WILL SERVICES BE PROVIDED?

Benefits will be provided when rendered in an Independence Blue Cross Member Hospital, including any Approved Hospital outside of the Philadelphia five-county area.

In a Hospital located in the Philadelphia five-county area, which is not a Member Hospital of Independence Blue Cross, the total allowable charges associated with the Inpatient or Outpatient services will be reduced by 50% and then the Coinsurance and/or Deductible amounts will be applied.

For all other Non-Member Facility Providers, the Plan will pay the specified Coinsurance level of the allowable charges, except where otherwise indicated, and subject to a Deductible if it has not been satisfied.

SECTION 4

MANAGED CARE PROVISIONS

A. HOSPITAL PRE-ADMISSION REVIEW

All Inpatient Admissions in Independence Blue Cross Member Hospitals must meet the requirements of the Independence Blue Cross's designated agent for utilization management ("designated agent"). Under the program, the admitting Physician for any Inpatient Admission, other than a maternity and emergency admission, must obtain precertification in accordance with the standards of Independence Blue Cross of the appropriateness of the admission. At or before the time of admission, the Hospital will verify the precertification with Independence Blue Cross. Independence Blue Cross will not authorize the Hospital admission if precertification is required and is not obtained in advance.

IS ANYONE PENALIZED IF THE PROCEDURES ARE NOT FOLLOWED?

Through its Provider agreements or otherwise, Independence Blue Cross and the Providers will hold the Subscriber harmless and the Subscriber will not be financially responsible for admissions which fail to conform to the above requirements unless (1) the Hospital provides prior written notice that the admission will not be paid by Independence Blue Cross, and (2) the Subscriber acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Hospital admission.

B. CONCURRENT REVIEW

Designated agent assigns an estimated length of stay for all approved Inpatient Hospital admissions. It also approves admissions to Skilled Nursing Facilities and other types of care provided by other Facility Providers and Professional Providers as provided for in this Section Managed Care Provisions. Concurrent review of an approved admission or plan of treatment may result in an approval of a request for an extension of approved care. Designated agent will verbally inform the Provider of the approval of any additional care as a result of the concurrent review. It will also continue to monitor extensions of care to determine when further Covered Services are no longer Medically Necessary/Medically Appropriate. The written determination by both designated agent and the attending physician that Covered Services are no longer Medically Necessary/Medically Appropriate will result in the termination of benefits payable for the treatment of the illness or injury.

C. INDIVIDUAL CASE MANAGEMENT

Any Subscriber who suffers from a catastrophic illness or injury may be eligible for Individual Case Management (ICM). ICM focuses on the reduction of Inpatient Hospital utilization and is designed to address the needs of selected high-risk patients by coordinating the delivery of quality and cost-effective treatment modalities commensurate with the patient's needs. ICM involves individual benefits management for complex long-term medical needs.

The Plan will identify cases where ICM may be appropriate for a Subscriber who suffers from a catastrophic illness or injury. Then the Plan will assess the Subscriber's anticipated medical needs, after consultation with the attending Physician, the Subscriber and the Subscriber's family, where necessary. However, ICM will be made available to the Subscriber if, and only if, all of the following criteria are met:

1. The Plan determines that, without ICM, the Subscriber will have to remain in a more costly setting to receive the appropriate quality or intensity of care;
2. The attending Physician determines that a different course of treatment or services is responsive to the needs of the Subscriber; and
3. The plan of treatment will be implemented only with the concurrence of the Plan, the contractholder, the attending Physician, the Subscriber and the Subscriber's family, where applicable.

Following implementation, ICM will continue until:

1. The Subscriber's medical goals (as identified in the approved Plan of Treatment) are met and additional services are not Medically Necessary/Medically Appropriate, as determined by the Plan;
2. In the opinion of the attending Physician, the Subscriber's condition no longer requires the services provided under the approved Plan of Treatment, and a different course of treatment is appropriate;
3. The Subscriber exhausts benefits provided under this Contract or under the approved Plan of Treatment; or
4. The contractholder, the Subscriber (or the Subscriber's family, where necessary) or the Plan terminates ICM upon appropriate notice.

D. DO I NEED PRE-AUTHORIZATION FOR OUTPATIENT PRIVATE DUTY NURSING SERVICES?

Yes. When the 100 hour limit has been reached, outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) must be submitted, in advance, to the Plan for medical review to determine Medical Appropriateness/Medical Necessity and eligibility under terms of this Contract. Call within Philadelphia at 215-241-2100 or outside Philadelphia at 1-800-227-3116 to obtain pre-authorization.

E. DO I NEED PRE-AUTHORIZATION FOR DURABLE MEDICAL EQUIPMENT?

Yes. Before you arrange to purchase or rent an item with a cost of \$1,500 or more you must first call within Philadelphia at 215-241-2100 or outside Philadelphia at 1-800-227-3116 to obtain pre-authorization.

SECTION 5

WHAT ARE THE SERVICES COVERED UNDER COMPSELECT?

When you are ill or injured, your coverage helps pay for Covered Services and Expenses performed by a Facility Provider, and/or a Professional Provider. Services must be deemed Medically Appropriate and Medically Necessary as determined by the Plan. Benefits will be paid in accordance with your Schedule of Benefits.

All Inpatient admissions, other than maternity or a medical emergency, must receive Pre-Certification in accordance with the requirements contained in Section 4 of this Booklet. Admissions for maternity or an emergency must be reviewed within two (2) business days of the admission. A concurrent review is required for any continued length of stay beyond what has been Pre-Certified by the Plan.

- **ROOM AND BOARD AND ANCILLARY SERVICES**

When you, or an eligible family member, are admitted to a Hospital, you are entitled to the following Medically Appropriate benefits:

- an average semi-private room, as designated by the Hospital; or a private room, when designated by the Plan as semi-private in Hospitals having primarily private rooms;
 - a private room, when Medically Appropriate;
 - a Special Care Unit, such as Intensive or Coronary Care;
 - general nursing services;
 - special meals and dietary services;
 - use of operating, delivery, nursery, recovery or other specialty service rooms;
 - casts, surgical dressings, and supplies;
 - oxygen and oxygen therapy;
 - administration of blood and blood plasma;
 - anesthesia;
 - therapy services;
 - prescribed drugs while inpatient;
 - diagnostic service;
 - preadmission testing.
- **INPATIENT MEDICAL VISITS** - You are covered for inpatient medical visits provided by a Professional Provider who is in charge of the case.
 - **INPATIENT CONSULTATION** - You are covered for consultations provided by a Professional Provider who is not in charge of the case.
 - **INPATIENT CONCURRENT CARE**

You are covered for Inpatient medical care rendered by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the patient,

stand-by services, routine preoperative physical examinations or medical care routinely performed in the pre- or post-operative or pre- or post-natal periods.

- **SURGICAL SERVICES**

You are covered for surgical services provided in or out of the Hospital by a Facility and/or Professional Provider.

- **SURGERY**

Surgery for the treatment of disease or injury is covered.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Plan will pay the Provider's reasonable charge for the highest paying procedure and no allowance for additional procedures except where the Plan deems that an additional allowance is warranted.

Also covered is (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for the initial and subsequent prosthetic devices to replace the removed breast or portions thereof.

- **ASSISTANT SURGERY**

Services of an assistant surgeon are covered when the condition of the patient or the type of surgery performed requires assistance.

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

- **ANESTHESIA**

Administration of anesthesia in connection with covered services when rendered by a Professional Provider, other than the surgeon, assistant surgeon or attending Professional Provider.

The medical direction (supervision) of anesthesia services administered by a nurse anesthetist not employed by a Professional Provider will be paid at 50% of the UCR allowance.

Anesthesia services, administered by an independently practicing certified registered nurse anesthetist (CRNA) working "in cooperation with" the surgeon, assistant surgeon, or attending Professional Provider will be paid at 100% of the UCR allowance.

Anesthesia services administered by an independently practicing certified registered nurse anesthetist (CRNA) under the medical direction (supervision) of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider will be paid at 50% of the UCR allowance.

- **TRANSPLANT SERVICES**

You are covered for human organ transplant services, including the covered services for the removal of an organ from a donor when the donor is not a subscriber and not covered under another health care plan. Benefits are provided only for those medical services directly and specifically related to the transplantation of human organs. No benefit will be payable for the purchase price of an organ or tissue for transplant procedures.

• **VOLUNTARY SECOND SURGICAL OPINION**

You are covered for the second opinion consultation 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 services must be performed and billed for by a Professional Provider other than the consultant who provided the patient with the initial surgical consultation. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances, you will be eligible for a maximum of two such out-of-hospital consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

• **ORAL SURGERY** - You are covered for the surgical removal of partial and bony impactions.

• **SPECIAL DENTAL SERVICES**

- Inpatient dental services are covered when in connection with dental procedures or surgery only when you have an existing non-dental physical disorder or condition.
- Dental services related to an accidental injury to the jaws, sound natural teeth, mouth or face are covered.

• **EMERGENCY ACCIDENT CARE**

Emergency treatments provided in an outpatient department are covered when initial services are provided within 3 days of the accident and follow-up care within 14 days, of the initial treatment.

• **EMERGENCY MEDICAL SERVICES**

Emergency treatments provided in an outpatient department are covered when initial services are provided within 3 days of emergency, and follow-up care within 14 days, of the initial treatment.

• **OUTPATIENT MEDICAL VISITS** - when provided in the home, office and outpatient department are covered.

• **PEDIATRIC IMMUNIZATIONS**

Benefits are provided for childhood immunizations which, as determined by the Pennsylvania Department of Health, conform with the standards of the (Advisory Committee

on Immunization Practices of the Center for Disease Control), U.S. Department of Health and Human Services.

Benefits for Immunizations are limited to Subscribers under the age of 21 and are not subject to Deductible, or benefit maximums.

- **ROUTINE GYNECOLOGICAL EXAMINATION AND PAPANICOLAOU SMEAR**

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination, and one (1) routine pap smear per calendar year for all female Subscribers. Benefits are exempt from Deductible, Coinsurance or benefit maximums.

- **MAMMOGRAPHY**

- One screening mammography is covered per calendar year for females 40 years of age and older. (This benefit is exempt from Deductible, Coinsurance or benefit maximums.) For females under age 40, all physician-recommended mammographies are covered.
- Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

- **MEDICAL FOODS AND NUTRITIONAL FORMULAS**

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an outpatient basis either orally or through a tube. Benefits are exempt from Deductible requirements.

Benefits are also payable for Nutritional Formulas when: (1) they are the sole source of nutrition for an individual (more than 75% of estimated basal caloric requirement) and the Nutritional Formula is given by way of a tube into the alimentary tract, or (2) the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Durable Medical Supplier or in connection with Infusion Therapy as provided for in this booklet.

- **DIAGNOSTIC SERVICES** - You are covered for:

- Diagnostic x-ray, consisting of radiology, ultrasound, and nuclear medicine;
- Diagnostic laboratory and pathology tests;
- ECG, EEG, and other diagnostic medical procedures;
- Allergy testing and immunotherapy.

- **THERAPY SERVICES** - You are covered for:

- Chemotherapy, Radiation Therapy and Infusion Therapy.
- Physical Therapy, Cardiac Therapy and Respiratory Therapy - On an outpatient basis, physical, cardiac and respiratory therapies are subject to an aggregate maximum of \$1,000 per person, per benefit period.
- **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, chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

- **MATERNITY SERVICES** including pre- and post-natal care are covered. Maternity care Inpatient benefits will be limited to 48 hours for vaginal deliveries and 96 hours for cesarean deliveries, except where otherwise approved by the Plan.

In the event of early post-partum discharge, benefits are provided for home health care as provided for in the subsection entitled HOME HEALTH CARE.

- Elective Abortions

Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by an Employee, spouse, or Dependent daughter are a Covered Expense under this Plan.

- **INPATIENT NEWBORN CARE**

- Professional visits to examine the newborn are covered while the newborn is an inpatient during the newborn's confinement in a Hospital or Birthing Center.

Benefits from the date of birth up to a maximum of 31 days are provided. To be eligible for coverage beyond the 31 day period, application must be made within this 31 day period to have the newborn child added as a dependent.

- **PSYCHIATRIC SERVICES**

Inpatient and Outpatient psychiatric services for Mental Illness and Serious Mental illness are covered up to the Maximum day and visit limitations per Benefit Period as stated in the Schedule of Benefits. Professional Provider visits for the treatment of mental illness (other than Serious Mental Illness) include treatment for drug abuse and alcoholism. You are covered for:

- Inpatient Treatment rendered by a Facility and/or Professional Provider. For treatment of Serious Mental Illness, the Covered Person may trade on a one (1) for two (2) basis: available inpatient days for Partial Hospitalization days or additional Outpatient Facility/Professional visits.

- Outpatient Psychiatric Services. For treatment of Serious Mental Illness, the Covered Person may trade on a one (1) for two (2) basis: available Inpatient days for additional Outpatient Facility/Professional Provider visits.
- Psychiatric Visits, Psychiatric Consultations, Individual and Group Psychotherapy, Electroconvulsive Therapy, Psychological Testing, Psychopharmacologic Management, and Psychoanalysis.

- **TREATMENT FOR ALCOHOL OR DRUG ABUSE AND DEPENDENCY**

PRIOR TO QUALIFYING FOR BENEFITS FOR INPATIENT DETOXIFICATION, REHABILITATION, HOSPITAL OR NON-HOSPITAL RESIDENTIAL TREATMENT, OR OUTPATIENT ALCOHOL OR DRUG SERVICES, A PHYSICIAN OR LICENSED PSYCHOLOGIST MUST (PRE) CERTIFY THAT THE SUBSCRIBER IS SUFFERING FROM ALCOHOL OR DRUG ABUSE OR DEPENDENCY. THIS REQUIREMENT IS IN ADDITION TO THE PROVISIONS FOR HOSPITAL PRE-CERTIFICATION CONTAINED IN THE MANAGED CARE SECTION.

Benefits are payable when provided by a Member Hospital or Member Facility Provider according to the following provisions and limitations:

1. **Inpatient Detoxification and Rehabilitation**

- Up to 7 days per admission; lifetime maximum of 4 admissions per Subscriber.
- Covered facility services include lodging and dietary services; physician, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-rays; psychiatric, psychological and medical laboratory testing; drugs, medicines, use of equipment and supplies.
- No benefits are payable for services provided by Non-Member Hospital Facility or a Non-contracting Non-hospital Facility.

2. **Hospital and Non-hospital Residential Treatment**

- Limited to 30 days per calendar year; lifetime maximum of 90 days per Subscriber.
- Additional days may be available as specified under Outpatient Alcohol or Drug Services.
- Covered facility services include lodging and dietary services; physician, psychologist, nurse, certified addictions counselor and trained staff services; rehabilitation therapy and counseling; psychiatric, psychological and medical laboratory testing; drugs, medicines, use of equipment and supplies.
- No benefits are payable for services provided by Non-Member Hospital Facility or a Non-contracting Non-hospital Facility.

3. Outpatient Alcohol or Drug Services

- Up to a maximum of 30 full outpatient session visits or an equivalent number of partial hospitalization visits per calendar year; lifetime maximum of 120 full session visits or an equivalent number of partial hospitalization visits per Subscriber.
- The Subscriber may trade off on a 2 for 1 basis up to 30 additional separate sessions of Outpatient Services per year in order to receive up to 15 additional days Hospital and Non-hospital Residential Alcohol treatment days. Any benefits exchanged or traded off under the terms of this provision are subject to, and do not increase, the overall lifetime maximum.
- Covered facility services include physician, psychologist, nurse, certified addictions counselor and trained staff services; rehabilitation therapy and counseling; family counseling and intervention; psychiatric, psychological and medical laboratory testing, drugs, medicines, use of equipment and supplies.

No benefits are payable for services provided by Non-Member Hospital Facility or a Non-contracting Non-hospital Facility.

- **SKILLED NURSING CARE FACILITY** - You are covered up to a maximum benefit of 30 days per benefit period and 35 physician visits per benefit period.

No benefits are payable for the treatment of alcoholism and drug addiction, and mental illness in a Skilled Nursing Care Facility.

- **DURABLE MEDICAL EQUIPMENT, ORTHOTIC AND PROSTHETIC DEVICES**

You are covered for the following:

- Rental or, at the Plan's option, purchase. Rental costs may not exceed the total cost of purchase.
- Prosthetic Appliances which replace all or part of an absent body limb or a permanently inoperative or malfunctioning body organ.
- Purchase, fitting, necessary adjustment, repair and replacement of prosthetic devices and supplies. This includes prosthetic devices inserted during the initial or subsequent reconstructive surgery incident to mastectomy. Benefit does not include dental appliances except when needed as the result of an accidental injury or the replacement of cataract lenses, except when new lenses are needed because of a prescription change.
- Eyeglasses or contact lenses required due to ocular surgery such as cataract surgery.
- Orthopedic braces necessary for alleviation or correction of conditions due to injury, illness, or congenital deformities. However, corrective shoes are excluded unless (1) such shoes are attached to orthopedic braces; or (2) such shoes or other podiatric appliances are used for the prevention of complications associated with diabetes.

ITEMS OVER \$1,500 MUST BE PREAUTHORIZED BY CALLING within Philadelphia at 215-241-2100 or outside Philadelphia at 1-800-227-3116.

- **HOME HEALTH CARE**

Benefits are provided for services performed by a Member Hospital program for Home Health Care or by a licensed Member Home Health Care Agency.

- Covered services include professional services of appropriately licensed and certified individuals; Skilled Nursing care, physical therapy, speech therapy, occupational therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Plan.
- Also covered is (a) care within 48 hours following release from an inpatient admission when the discharge occurs within 48 hours following a mastectomy; (b) in the event of early post-partum discharge, care within 48 hours of a vaginal delivery or 96 hours of a cesarean delivery; and (c) well mother/well baby care following release from an inpatient maternity stay.
- A written Plan of Treatment prepared by the Provider is required; and
- You must be homebound to be eligible for home health care benefits.

No Home Health Care benefits for the following when provided by a Home Health Care Agency: services which exceed the specified limits of liability; custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance; private duty nurses; rental or purchase of durable medical equipment; rental or purchase of medical appliances (e.g., braces) and prosthetic devices; (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices; prescription drugs; services provided by a member of the patient's family or the family of the patient's spouse; patient's transportation, including services provided by voluntary ambulance associations for which the patient 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 service; services provided to individuals who are not essentially homebound for medical reasons; and visits by any provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the provider.

- **HOSPICE SERVICES**

- Covered services include nursing services, medical social services, physician services, physical therapy, occupational therapy, speech/language pathology services, home health aides and homemaker services, counseling and bereavement, dietary and spiritual counseling.
- Respite care in a Medicare Certified Skilled Nursing Facility for up to 7 days every six months is covered.
- Benefits will be provided to the earlier of the patient's death or discharge from the Hospice.

- The Hospice Care Program must deliver Hospice Care in accordance with a treatment plan approved by and periodically reviewed by the Plan.
- No Hospice Care benefits will be provided for: services and supplies for which there is no charge; research studies directed to life lengthening methods of treatment; services or expenses incurred in regard to the patient's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property); and care provided by family members, relatives, and friends.

- **DIABETIC EDUCATION PROGRAM**

Benefits are provided 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 prescribed by a Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Subscriber requires diabetic education on an outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Member Hospital or other entity under contract with Blue Cross. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Plan. These requirements are based upon the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include outpatient sessions that include, but may not be limited to, the following information:

- initial assessment of the patient's needs;
- family involvement and/or social support;
- psychological adjustment for the patient;
- general facts/overview on diabetes;
- nutrition including its impact on blood glucose levels;
- exercise and activity;
- medications
- monitoring and use of the monitoring results;
- prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
- use of community resources; and
- pregnancy and gestational diabetes, if applicable.

Benefits are exempt from Deductible requirements.

- **BLOOD**

- You are covered for blood that is not replaced or donated.

- The first 2 pints of blood each benefit period are not covered.

- **PRESCRIPTION DRUGS/MEDICINES**

Benefits will be provided for insulin, insulin analogs and pharmacological agents to control blood sugar as prescribed by a Physician and dispensed by a licensed Pharmacy. Benefits are available for up to a 30 day supply per Prescription order or refill. No other Prescription Drugs are covered.

- **AMBULANCE**

You are covered for transportation from your home or the scene of an accident or medical emergency to the nearest Hospitals.

Air or Sea ambulance transportation benefits are payable only if the Plan determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air instead of another means of transportation.

- Maximum benefit for ground transportation is \$250 per Benefit Period.

- **OUTPATIENT PRIVATE DUTY NURSING SERVICES - R.N. or L.P.N.**

You are covered for outpatient private duty nursing services provided by an R.N. or L.P.N.

- After 100 hours of services, all additional services must be Pre-Authorized by contacting our office within Philadelphia at 215-241-2100 or outside Philadelphia at 1-800-227-3116.
- No Benefits will be provided for a nurse who ordinarily resides in the patient's home or a member of the patient's immediate family, for services by a home health aide or nurses aide.
- Benefits are not payable for:
 - (a) nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication.
 - (b) services provided by a nurse who ordinarily resides in the Subscriber's home or is a member of the Subscriber's immediate family;
 - (c) services provided by a home health aide or a nurses's aide; and
 - (d) services which have not been Pre-Authorized by the Plan.

- **DIABETIC EQUIPMENT AND SUPPLIES**

Benefits shall be provided, subject to any applicable Deductible and Coinsurance, or pre-certification requirement for the following diabetic equipment and supplies furnished by a Pharmacy or Durable Medical Supplier.

1. Diabetic Equipment

- a) blood glucose monitors*
- b) insulin pumps*
- c) insulin infusion devices*; and
- d) orthotic and podiatric appliances for the prevention of complications associated with diabetes*

*Pre-certification is required for the purchase of equipment that exceeds \$1,500 in purchase price. Applicable Deductible and Coinsurance amounts will apply to this benefit.

2. Diabetic Supplies

- a) monitor supplies;
- b) blood testing strips;
- c) visual reading and urine test strips;
- d) injection aids;
- e) **insulin and insulin analogs;
- e) insulin syringes;
- f) lancets and lancet devices;
- g) **pharmacological agents for controlling blood sugar levels; and
- h) glucagon emergency kits.

**Covered under Prescription Drug benefit.

• DAY REHABILITATION PROGRAM

Subject to the limits shown in the **Schedule of Benefits**, benefits will be provided for a Medically Appropriate/Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

1. The Subscriber requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five (5) days per week for 4-7 hours per day;
2. The Subscriber has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;
3. The Subscriber is willing to participate in a Day Rehabilitation Program; and
4. The Subscriber'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.

SECTION 6

WHAT IS NOT COVERED

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

- Which are not Medically Necessary/Medically Appropriate as determined by the Plan for the diagnosis or treatment of illness or injury;
- Which are Experimental or Investigative in nature;
- Which were Incurred prior to the Subscriber's Effective Date of coverage;
- Which were or are incurred after the date of termination of the Subscriber's coverage;
- For any illness contracted or injury sustained during military service while on active duty or any act of war, whether declared or undeclared;
- For which a Subscriber would have no legal obligation to pay in the absence of this or any similar coverage;
- 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;
- Paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is "payable under Medicare" when the Subscriber is eligible to enroll for Medicare benefits, regardless of whether the Subscriber actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
- 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 the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Subscriber claims the benefits or compensation;
- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- 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;
- Which are not billed and performed by a provider unless otherwise indicated;
- Which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;

- Rendered by a member of the Subscriber's Immediate Family;
- 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 ambulance services except as specifically provided in this booklet;
- 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, except as required by law. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct 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 in the COVERED SERVICES Section of this booklet;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For music therapy;
- For marriage counseling;
- For Custodial Care, domiciliary care or rest cures;
- For equipment costs related to services performed on high cost technological equipment as defined by Blue Shield, 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 Blue Shield;
- For pre-operative care and any post-operative care other than that normally provided following operative or cutting procedures;
- For Outpatient Occupational Therapy and supplies; Outpatient Speech Therapy;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as specifically stated in the Group Contract. These include, but are not limited to, apicoectomy (dental root resection), 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 unless otherwise indicated. This exclusion does not apply to orthodontic treatment for congenital cleft palates as provided for and defined in the COVERED SERVICES Section of this booklet;
- 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;

- For palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For supportive devices for the foot (orthotics) for palliative care, except for orthotics and podiatric appliances for the prevention of complications associated with diabetes;
- For hearing aids or hearing examinations or tests for the prescription or fitting of hearing aids;
- For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;
- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT);
- For treatment of sexual dysfunction not related to organic disease or injury;
- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs, chairlifts, stairglides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a Provider;
- For the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column;
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- For well-baby care, except as provided in the pediatric immunization benefit;
- For routine or periodic physical examinations and diagnostic studies, except for routine gynecological examinations as provided herein;
- For diagnostic screening examinations, except for mammograms and pap smears as stated in this booklet;
- For weight reduction, premarital examinations and premarital blood tests;
- For research studies;

- For an inpatient confinement incurred only for the purposes of diagnosis, diagnostic study or medical observation;
- For charges in excess of the Usual, Customary and Reasonable Allowance for the services or supplies furnished;
- For acupuncture;
- For travel, whether or not it has been recommended by a Professional Provider or it is required to receive treatment at an out-of-area provider;
- Immunizations required for employment purposes, or for travel;
- For Prescription Drugs except insulin analogs and pharmacological agents for controlling blood sugar levels;
- For routine neonatal circumcision;
- For any sterilization procedures or the reversal of such procedures;
- For amino acid supplements, appetite suppressants, and nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for in the COVERED SERVICES Section of this booklet;
- For medical supplies such as, but not limited to, thermometers, ovulation kits, early pregnancy or home pregnancy testing kits, and home blood pressure machines, except for pregnancy-induced hypertension and hypertension complicated by pregnancy;
- For Inpatient Private Duty Nursing services;
- Any care that extends beyond traditional medical management for autistic disease of childhood, pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;
- For charges incurred for expenses in excess of benefit maximums as specified in this booklet;
- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children;
- For Maintenance of chronic conditions, injuries or illness when response to treatment has reached the maximum therapeutic level, no additional functional improvement can be demonstrated or anticipated, and continuation of the service will be of no therapeutic value to the Subscriber;

- For counseling or consultation with a patient's relatives, or Hospital charges for a patient's relatives or guests, except as may be specifically provided in this Booklet;
- For any other service or treatment except as provided in this Booklet.

SECTION 7

OTHER INFORMATION

COORDINATION OF BENEFITS

1. Definitions

In addition to the Definitions of this Contract for purposes of this Provision only:

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

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

The definition "Plan" does not include any group-type plan that provides hospital indemnity benefits of less than \$200 per day.

2. Determination of Benefits

Coordination of Benefits (COB) applies when a Subscriber has health care coverage under any other group health care plan (Plan) for services covered under this Contract, or when the Subscriber 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 Blue Cross and Blue Shield and the other Plan in order to avoid duplication of benefits.

Benefits under this Contract will be provided in full when Blue Cross and Blue Shield are primary, that is, when Blue Cross and Blue Shield determine benefits first. If another Plan is primary, Blue Cross and Blue Shield will provide benefits as described below.

When a Subscriber has group health care coverage under this Contract and another Plan, the following will apply to determine which coverage is primary:

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

- b) If the other Plan includes rules for coordinating benefits:
- 1) The Plan covering the patient other than as a Dependent shall be primary.
 - 2) 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 longer shall be primary. However, if the other Plan does not have the birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child's parents are separated or divorced.
 - 3) Except as provided in subparagraph (4) below, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
 - i) First, the Plan covering the child as a Dependent of the parent with custody;
 - ii) then, the Plan of spouse of the parent with custody of the child;
 - iii) finally, the Plan of the parent not having custody of the child.
 - 4) 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.
 - 5) 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 2 (b) (2).
- c) The Plan covering the patient as a Subscriber who is neither laid off nor retired (or as that Subscriber's Dependent) is primary to a Plan which covers that patient as a laid off or retired Subscriber (or as that Subscriber'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.
- d) If none of the above rules apply, the Plan which covered a Subscriber longer shall be primary.

3. **Effect on Benefits**

When Blue Cross and Blue Shield are secondary, the benefits under this Contract will be reduced so that Blue Cross and Blue Shield will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Contract and the total Covered Services provided to the Subscriber. Benefits payable under another Plan include benefits that would have been payable had the claim been

duly made therefore. In no event will a Blue Cross and Blue Shield payment exceed the amount that would have been payable under this Contract if Blue Cross and Blue Shield were primary.

When the benefits are reduced under the Primary plan because a Subscriber 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 those related to second surgical opinions, pre-certification admission and services, and Preferred Provider arrangements.

Certain facts are needed to apply COB. Blue Cross and Blue Shield have the right to decide which facts are needed. Blue Cross and Blue Shield 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 Blue Cross and Blue Shield deem necessary for such purposes. Any person claiming benefits under this Contract shall furnish to Blue Cross and Blue Shield such information as may be necessary to implement this provision. Blue Cross and Blue Shield, 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 Contract shall be affected by the benefits that would be payable under any and all other Plans only to the extent that Blue Cross and Blue Shield are furnished with information relative to such other Plans.

4. **Right of Recovery**

Whenever payments which should have been made under this Contract in accordance with this provision have been made under any other Plan, Blue Cross and Blue Shield 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 Contract and, to the extent of such payments, Blue Cross and Blue Shield shall be fully discharged from liability under this Contract. Whenever payments have been made by Blue Cross and Blue Shield 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, Blue Cross and Blue Shield shall have the right to recover such payments to the extent of such excess from among one or more of the following, as Blue Cross and Blue Shield shall determine:

1. the person Blue Cross and Blue Shield has paid or for whom they have paid;
2. insurance companies; or
3. any other organizations.

The Subscriber, on his own behalf and on behalf of his Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to Blue Cross and Blue Shield.

SUBROGATION

If any benefit is provided to the Subscriber under this agreement, Blue Cross and Blue Shield shall be subrogated and succeed to the Subscriber's rights of recovery with respect to the services and supplies involved against a responsible third party and/or insurance company.

Subrogation means that if you or your enrolled dependent(s) are injured because of the negligence or wrong doing of another party, Blue Cross and Blue Shield have the right to seek recovery of benefits paid for related expenses. You are expected to take any action necessary to protect and to assure the subrogation rights of the Blue Cross and Blue Shield Plans.

This provision shall be unenforceable when prohibited by law.

PAYMENT OF BENEFITS

The Subscriber or the Provider may submit bills directly to the Plan and, to the extent that benefits and indemnity are payable within the terms and conditions of the Contract, reimbursement will be furnished as detailed below. The Subscriber's Deductibles, Coinsurance, benefit Maximums and benefits for Covered Services are based on the rate of reimbursement as defined under "Covered Expense" in the DEFINITIONS section of this booklet.

1. Facility Providers

- (a) Independence Blue Cross or any other Blue Cross Plan will compensate the Member Facility Providers periodically in accordance with the contracts entered into between such Member Facility Providers and the Plan. No payment will be made directly to the Subscriber for Covered Services rendered by any Member Facility Provider.
- (b) Independence Blue Cross will indemnify the Applicant-Subscriber directly for services provided by Non-Member Facility Providers located within the Philadelphia 5-County. No payment will be made directly to such Non-Member Facility Providers.
- (c) Independence Blue Cross or any other Blue Cross Plan will provide benefits for the Covered Expenses Incurred for certain medical services when rendered incident to hospitalization, as described herein. If bills for such services are included in a Member Facility Provider's bill, payment shall be made to such Member Facility Provider subject to the existing arrangements with the Member Facility Provider. If bills for such services are submitted by the Physician to the Subscriber, the Subscriber shall forward the bills directly to the Plan for payment, and the Subscriber will be indemnified for such services.

2. Professional Providers

- (a) Blue Shield is authorized by the Subscriber to make payment directly to the Participating Professional Providers furnishing Covered Services for which benefits are provided under this Contract. However, Blue Shield reserves the right to make payments directly to the Subscriber.
- (b) For Covered Services provided by Non-Participating Professional Providers, Blue Shield reserves the right to pay benefits directly to the Subscriber.

3. Ancillary Providers and Pharmacies

- (a) Independence Blue Cross will compensate Contracting Ancillary Providers (and Contracting Pharmacies, if applicable), in accordance with the contracts entered into

between such Contracting Providers and the Plan. No payment will be made directly to the Subscriber for Covered Services rendered by a Contracting Ancillary Provider.

- (b) Independence Blue Cross will pay the Subscriber directly for services provided by a Non-Contracting Provider.

4. **Assignment of Benefits**

The right of a Subscriber to receive benefit payments under this Contract is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital or other entity nor may benefits of this Contract be transferred, either before or after Covered Services are rendered. However, a Subscriber can assign benefit payments to the custodial parent of a Dependent covered under this Contract, as required by law.

Once Covered Services are rendered by a Provider, the Plan will not honor Subscriber requests not to pay the claims submitted by the Provider. The Plan will have no liability to any person because of its rejection of the request.

SERVICE BENEFITS

If you had services performed by a Highmark Blue Shield Participating Professional Provider, and the Provider should bill you for other than the deductible, co-insurance, amounts exceeding the maximum or ineligible services, do the following:

Discuss the situation with the Provider.

If you do not come to a mutually satisfactory settlement of the disagreement, then:

- 1) Contact Highmark Blue Shield in writing at:
P.O. Box 898847, Camp Hill, PA 17089-8847.
- 2) Advise Blue Shield of the situation.

Blue Shield will review the situation to resolve the disagreement. The decision by Blue Shield shall be final.

RESOLVING PROBLEMS (COMPLAINTS/APPEALS)

For purposes of this section only, the term “Member” replaces the term “Subscriber.”

Member Complaint Process

The Plan has a process for Members to express informal complaints. To register a complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Plan at the following address:

Independence Blue Cross
General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Plan is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within thirty (30) days.

Member Appeal Process

Filing an Appeal. The Plan maintains procedures for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Plan stating an adverse benefit determination. An appeal occurs when the Member or another authorized representative requests a change of a previous decision made by the Plan by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact the Plan as directed below to obtain a form for a member/enrollee to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Plan, as stated 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 Phone: 1-888-671-5276
Toll Free Fax: 1-888-671-5274 or
Phila. Fax: 215-988-6558**

Types of Member Appeals and Timeframe Classifications. Following are the two types of Member appeals and the issues they address:

- Medical Necessity Appeal Issues – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity or Medical Appropriateness and requests the Plan 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 Issues – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Plan decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

- Standard Pre-service appeal - An appeal for benefits that, under the terms of the Plan, 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.
- Standard Post-service appeal - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)
- Expedited/Urgent appeal – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Plan will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member’s life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist’s Report. You may submit to the Plan additional information pertaining to your case. You may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, the Plan will provide you or your authorized representative access to, and copies of, documents, records, and other information relevant to the appeal that is provided for the appeal decisionmaker(s) to review.

Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Appeal Committee Composition and Role. Each Appeal Committee described below will be comprised of one to three persons designated by the Plan to act as decisionmaker(s) on the appeal. The Committee decisionmaker(s) did not make the adverse benefit determination at issue in the appeal and are not subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or his authorized representative or obtained from other sources during the investigation of the appeal issues.

STANDARD APPEALS: Process and timeframes.

An acknowledgement letter and description of the appeal process is mailed following receipt of a Member appeal. A standard appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframes:

Standard Pre-service Appeal – within 30 days of receipt of the appeal request
Standard Post-service Appeal – within 60 days of receipt of the appeal request

The appeal review will occur based on the information available for the Appeal Committee’s review. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

Written notice of the standard appeal decision will be sent within the timeframes stated above. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you about relevant information that is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you.

The standard appeal decision is final with respect to your right to appeal through the Plan’s internal member appeal process.

EXPEDITED APPEALS: Process and timeframes

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframe:

Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.

To request an expedited appeal by the Plan, call or fax the Member Appeals Department at the phone numbers listed above under “Filing an Appeal.” Information related to your appeal will be requested and you will be promptly informed whether it qualifies for review as an expedited appeal or must instead be processed as a standard appeal.

The Expedited Appeal Committee will review all relevant information for the appeal from the Member or his authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an expedited appeal. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

The Expedited Appeal review will be completed promptly based on your health condition, but no later than seventy-two (72) hours after receipt of your expedited appeal by the Plan. You will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you. The expedited appeal decision is then final with respect to a Member’s right to appeal through the Plan’s internal appeal process.

The policy and procedures for Member appeals may change due to changes that the Plan makes to comply with applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting agencies, or to otherwise improve the Member Appeals process.

SECTION 8

DEFINITION OF TERMS

The following definition of terms will be helpful to you in fully understanding your benefits:

ACCIDENTAL INJURY - a bodily injury which results from an accident directly and independently of all other causes.

ACCREDITED EDUCATIONAL INSTITUTION – a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conferment of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education. The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

ALCOHOL OR DRUG ABUSE - any use of alcohol or other drugs which produce a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

AMBULANCE SERVICES - includes air ambulance if Medically Appropriate/Necessary, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured. This includes transportation: from a Subscriber's home or the scene of an accident or medical emergency to the nearest Hospital; between Hospital and Skilled Nursing Facility or between hospitals.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the Plan and which:

- A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
- B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- C. does not provide Inpatient accommodations; and
- D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

ANCILLARY PROVIDER - an individual or entity that provides services, supplies or equipment, (such as but not limited to Infusion Therapy services, Durable Medical Equipment and

ambulance services), for which benefits are provided under the Plan and which is not classified as either a Facility Provider, a Professional Provider or a Pharmacy.

ANESTHESIA - consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

APPROVED HOSPITAL - (1) any Hospital located in the Philadelphia 5-County Area (Bucks, Chester, Delaware, Montgomery and Philadelphia Counties) which has a contract with Independence Blue Cross; (2) any Hospital located outside of the Philadelphia 5-County Area which has a contract with any Blue Cross Plan; and (3) any Hospital located outside of the Philadelphia 5-County Area which is approved by the Joint Commission on Accreditation of Healthcare Organizations, by the American Osteopathic Hospital Association or by the appropriate Blue Cross Plan.

ASSISTANT SURGEON - Surgeon who actively assists the operating surgeon when the condition of the patient or the type of surgery performed requires assistance.

ATTENTION DEFICIT DISORDER - a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

BENEFIT PERIOD - the specified period of time as shown in the Schedule of Benefits during which charges for Covered Services must be incurred in order to be eligible for payment by the Plan. A charge shall be considered incurred on the date the service or supply was provided to a Subscriber.

BIRTH CENTER - means a Facility Provider approved by the Plan which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a Physician or a licensed certified nurse-midwife.

CERTIFIED REGISTERED NURSE - a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

COINSURANCE - the specific percentage of Covered Expenses which must be paid by the Subscriber.

COMPREHENSIVE MAJOR MEDICAL ALLOWANCE – the amount determined by the Plan to be reasonable for a Covered Service. The Comprehensive Major Medical Allowance is based on the Provider's charge in the geographic region where the Covered Service is provided, but may be adjusted to maintain reasonableness. Reasonableness is the amount that is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided. If no comparison exists, the Plan determines what is reasonable by the severity and/or complexity of the patient's condition for which the service or supply is provided. The Comprehensive Major Medical allowance established under this contract may differ from any Major Medical allowance established by other Blue Cross Plans and Highmark Blue Shield in other regions of Pennsylvania.

CONTRACT - the agreement, including the Group Application, riders and/or endorsements if any, between the Plan and the Group, also referred to as the Group Contract.

CONTRACTING ANCILLARY PROVIDER - an individual or entity that meets the definition of Ancillary Provider and has an agreement with the Plan pertaining to payment for the sale or rental of services and/or supplies.

CONTRACTING ANCILLARY PROVIDER'S ALLOWANCE - the maximum payment amount determined by the Plan for a Contracting Ancillary Provider.

CO-PAYMENT - a specified amount of expenses applied to a specific Covered Service for which the Subscriber is responsible per Covered Service.

COVERED EXPENSE - refers to the basis on which a Subscriber's deductibles, coinsurance, benefit maximums and benefits will be calculated.

- (a) For services rendered by a Facility Provider, the term "Covered Expense" may not refer to the actual amount(s) paid by the Plan to the Provider(s). Under IBC's contracts, IBC pays Facility Providers using bulk purchasing arrangements that permit IBC to pay less for services and enable it to offer the IBC Plan-wide Discount to all of its customers. The amount IBC pays at the time of any given claim may be more and it may be less than the amount used to calculate Subscriber liability. Rather, "Covered Expense" means the following:
 - i. For services rendered by a Member Facility Provider, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Plan-wide Discount in effect at the time the services are rendered;
 - ii. For services rendered by a Non-Member Facility Provider, "Covered Expense" means the lesser of the: (a) Facility Provider's charges, (b) Medicare Allowable Payment, and (c) Comprehensive Major Medical Allowance, for the Covered Services.
- (b) For services rendered by a Professional Provider, "Covered Expense" means the Provider's Reasonable Charge for the Covered Services.
- (c) For services rendered by Ancillary Providers and Pharmacies, "Covered Expense" means the following:
 - i. For services rendered by a Contracting Ancillary Provider or a Contracting Pharmacy, "Covered Expense" means the amount that the Plan has negotiated or the charge, whichever is less;
 - ii. For services rendered by a Non-Contracting Ancillary Provider or Non-Contracting Pharmacy, "Covered Expense" means the lesser of the: (a) Provider's charges, (b) Medicare Allowable Payment, and (c) Comprehensive Major Medical Allowance, for the Covered Services.

COVERED SERVICE - a service or supply specified in this booklet for which benefits will be provided.

CUSTODIAL CARE - care provided primarily for maintenance of the patient or 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 but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skill for professional training of medical or nursing personnel in order to be performed safely and effectively.

DAY REHABILITATION PROGRAM – is a level of Outpatient care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Plan and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Subscriber returns home each evening and for the entire weekend.

DEDUCTIBLE - a specified amount of Covered Expenses for the Covered Services usually expressed in dollars that must be paid by the Subscriber before the Plan will assume any liability.

DEPENDENT - means:

- (a) a Subscriber's spouse under a legally valid existing marriage;
- (b) a Subscriber's unmarried child who is continuously financially supported by the Subscriber, or whose coverage is the responsibility of the Subscriber under the terms of a release or court order, (including any stepchild or legally adopted child or child pending formal adoption) under age 19. If an unmarried child age 19 is a full-time student in an Accredited Educational Institution, he is dependent until he reaches age 23; and
- (c) a Subscriber's unmarried child age 19 or older who, as determined by the Plan, is incapable of self-support due to physical or mental incapacitation.

Dependent does not include a person who is: (a) an eligible Subscriber; or (b) a member of the armed forces.

DETOXIFICATION - means the process by which an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a licensed Facility Provider, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drug, or alcohol and other drug dependency factors or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

DURABLE MEDICAL EQUIPMENT - is equipment which:

- A. can withstand repeated use;
- B. is primarily and customarily used to service a medical purpose;
- C. generally is not useful to a person in the absence of an illness or injury; and
- D. is appropriate for use in the home.

Benefits for replacement of a prosthetic device will be provided only when Medically Necessary.

EFFECTIVE DATE - the date on which coverage for a Subscriber begins.

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:

- a. placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;
- b. serious impairment to bodily functions; or
- c. serious dysfunction of any bodily organ or part.

EMERGENCY CARE - Covered Services provided to a Covered Person in an Emergency, including Emergency Accident and Emergency Medical.

EMPLOYEE - an individual of the Group who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

ENTERAL NUTRITION - is the provision of nutritional requirements through a tube into the stomach or small intestine.

EXPERIMENTAL OR INVESTIGATIVE - a drug, device, medical treatment or procedure:

- A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
- B. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treatment facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- C. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study 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; or
- D. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary 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; or
- E. Any drug which the FDA has determined to be contraindicated for the specific treatment for which such drug is prescribed.

FACILITY PROVIDER - an institution or entity licensed, where required, to provide care. Such facilities are:

Ambulatory Surgical Facility	Hospital
Birth Center	Psychiatric Hospital
Free-Standing Ambulatory Care Facility	Rehabilitation Hospital
Freestanding Dialysis Facility	Residential Treatment
Home Health Care Agency Facility	Short Procedure Unit
Hospice	Skilled Nursing Facility

FAMILY COVERAGE - for the Subscribers and one or more of the Subscriber's Dependents.

FREE-STANDING AMBULATORY CARE FACILITY - a facility, other than a Hospital, which provides treatment or services on an outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a physician. This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREE-STANDING DIALYSIS FACILITY - A Facility Provider, licensed or approved by the appropriate governmental agency and approved by the Plan, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

GENERIC DRUG - means any form of a particular drug which is (1) sold by a manufacturer other than the original patent holder, (2) approved by the Federal Food and Drug Administration as generically equivalent, and (3) in compliance with applicable state laws and regulations.

HOME HEALTH CARE AGENCY - means a Facility Provider, approved by the Plan, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of Treatment.

HOSPICE - means a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) Certified by Medicare to provide Hospice services, or accredited as a Hospice by the Joint Commission on Accreditation of Healthcare Organizations; and (2) appropriately licensed in the state where it is located.

HOSPICE CARE SERVICES - care provided by a Hospice in the home for terminally ill patients who have a life expectancy of six months or less when certified by the attending physician and when the patient elects to receive care primarily in the home.

HOSPITAL - 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 Plan and which:

- (a) is a duly licensed institution;
- (b) 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;
- (c) has organized departments of medicine and major surgery;
- (d) provides 24-hour nursing service by or under the supervision of Registered Nurses;

(e) is not, other than incidentally, a:

- Skilled Nursing Facility;
- Nursing Home;
- Custodial Care Home;
- Health Resort, spa or sanitarium;
- Place for rest;
- Place for aged;
- Place for treatment of Mental Illness;
- Place for treatment of alcoholism or drug abuse;
- Place for provision of rehabilitation care;
- Place for treatment of pulmonary tuberculosis;
- Place for provision of hospice care.

IDENTIFICATION CARD - shall mean the currently effective card issued to the Applicant-Subscriber by the Plan.

IMMEDIATE FAMILY - the Subscriber'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.

INCURRED - a charge shall be considered incurred on the date a Subscriber receives the service or supply for which the charge is made.

INDEPENDENCE BLUE CROSS (IBC) PLAN-WIDE DISCOUNT - the percentage reduction from hospital charges for Covered Services that the Pennsylvania Insurance Department has approved for IBC to pass on to its customers as a share of the savings IBC is expected to realize from its negotiated hospital contracts. The amount of the discount may be changed prospectively from time to time with the approval of the Pennsylvania Insurance Department. The IBC Plan-Wide Discount is on file with the Pennsylvania Insurance Department.

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 or (INPATIENT) - means the actual entry into a Hospital, extended care facility or Facility Provider of a Subscriber who is to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Facility Provider and for whom a room and board charge is made; the Inpatient Admission shall continue until such time as the Subscriber is actually discharged from the facility.

INPATIENT CONCURRENT CARE - inpatient medical care rendered by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the patient, stand-by services, routine preoperative physical examinations or medical care routinely performed in the pre- or post-operative or pre- or post-natal periods.

INPATIENT DETOXIFICATION AND REHABILITATION - means the provision of medical, nursing, counseling or therapeutic services twenty-four hours a day in a Hospital or Non-hospital Facility, according to individual treatment plans.

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.

MAINTENANCE - continuation of care and management of the patient when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Services for a condition ceases to be of therapeutic value.

MAXIMUM - the greatest amount payable by the Plan for Covered Services. This could be expressed in dollars, number of days, or number of services for a specified period of time.

- a. Benefit Maximum - the greatest amount payable by the Plan for a specific Covered Service.
- b. Lifetime Maximum - the greatest amount payable by the Plan in a person's Lifetime.

MEDICAL CARE - professional services rendered by a Provider within the scope of his or her license for the treatment of an illness or injury.

MEDICAL FOODS - liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

MEDICALLY APPROPRIATE (or MEDICAL APPROPRIATENESS) - means services or supplies provided by a Facility Provider that the Plan determines are:

- (A) ordered by a Professional Provider or other appropriately licensed health care professional; and
- (B) required for the diagnosis, or the direct care and treatment of the subscriber's condition, illness, disease or injury; and
- (C) appropriate for the symptoms and diagnosis or treatment of the subscriber's condition, illness, disease or injury; and
- (D) in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and
- (E) not primarily for the convenience of the Subscriber's Family, or of the Facility Provider or Professional Provider; and
- (F) the most efficient and economical supply or level of service that can safely be provided to the Subscriber. When applied to hospitalization, this further means that the Subscriber requires acute care as a bed patient due to the nature of the services rendered or the Subscriber's conditions, and the Subscriber cannot receive safe and adequate care in some other setting without adversely affecting the Subscriber's condition or quality of medical care.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) - services or supplies provided by a Professional Provider that the Plan determines are:

- A. appropriate for the symptoms and diagnosis or treatment of the Subscriber's condition, illness, disease or injury;
- B. provided for the diagnosis, or the direct care and treatment of the Subscriber's condition, illness, disease or injury;
- C. in accordance with current standards of good medical practice;
- D. not primarily for the convenience of the Subscriber, or the Subscriber's Professional Provider; and

- E. the most appropriate supply or level of service that can safely be provided to the Subscriber. When applied to hospitalization, this further means that the Subscriber requires acute care as a bed patient due to the nature of the services rendered or the Subscriber's condition, and the Subscriber cannot receive safe or adequate care as an Outpatient.

The Subscriber or the Subscriber's Professional Provider may contact Highmark Blue Shield to determine whether a service is considered to be Medically Necessary.

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 – the payment amount, as determined by the Medicare program, for a Covered Service or supply.

MEMBER HOME HEALTH CARE AGENCY - means a Home Health Care Agency which has a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of services to Subscribers.

MEMBER HOSPICE - means a Hospice which has a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of Hospice services to Subscribers.

MEMBER HOSPITAL - means a Hospital that is approved by and has a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of services to Subscribers.

MEMBER OUTPATIENT PSYCHIATRIC FACILITY - means a Facility Provider which is approved by and has a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of Outpatient diagnostic and therapeutic psychiatric services to Subscribers.

MEMBER PROVIDER - means any Facility Provider of health care services, medical supplies, or Prescription Drugs which has a contract with Independence Blue Cross for the provision of such services, supplies or Prescription Drugs to Subscribers.

MENTAL ILLNESS - means and includes mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, effective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

NON-CONTRACTING ANCILLARY PROVIDER - an individual or entity that meets the definition of Ancillary Provider and does not have an agreement with the Plan pertaining to payment for the sale or rental of services and/or supplies.

NON-HOSPITAL FACILITY - means a Facility Provider, licensed by the Department of Health and approved by the Plan, for the care or treatment of Alcohol or Drug dependent persons, except for transitional living facilities.

NON-HOSPITAL RESIDENTIAL TREATMENT - means the provision of medical, nursing, counseling or therapeutic services to patients suffering from Alcohol or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

NON-MEMBER HOSPICE - means a Hospice which does not have a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of Hospice services to Subscribers.

NON-MEMBER HOSPITAL - means a Hospital which does not have a contract with Independence Blue Cross for the provision of services to Subscribers.

NON-MEMBER OUTPATIENT PSYCHIATRIC FACILITY - means a Facility Provider which does not have a contract with Independence Blue Cross or any other Blue Cross Plan for the provision of Outpatient diagnostic and therapeutic psychiatric services to Subscribers.

NON-MEMBER PROVIDER - means any Facility Provider of health care services, medical supplies, or Prescription Drugs that does not have a contract with Independence Blue Cross for the provision of such services, supplies or Prescription Drugs to Subscribers.

NON-PARTICIPATING PROFESSIONAL PROVIDER - a Professional Provider who does not meet the definition of a Participating Professional Provider.

NON-PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who does not meet the definition of a Preferred Professional Provider.

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 Subscriber for Covered Services in a Benefit Period. Such expense does not include any Deductible, penalties, psychiatric care services, copayment amounts, or charges in excess of the Provider's Reasonable Charge. When the Out-of-Pocket Limit, as specified in the Schedule of Benefits is reached, the level of benefits is increased.

OUTPATIENT - a Subscriber who receives services or supplies while not an Inpatient.

OUTPATIENT DIABETIC EDUCATION PROGRAM - means an Outpatient Diabetic Education Program provided by a Member Hospital of Independence Blue Cross, which has been recognized by the Pennsylvania 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.

PARTICIPATING PROFESSIONAL PROVIDER - A Professional Provider who has an agreement with Highmark Blue Shield pertaining to payment for Covered Services rendered to a Subscriber.

PARTIAL HOSPITALIZATION - means medical, nursing, counseling or therapeutic services 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 but who does not require Inpatient confinement.

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 - means an individual who is legally licensed to practice the profession of Pharmacology and who regularly practices such profession in a Pharmacy.

PHARMACY - means an establishment which is registered and licensed as a Pharmacy with the appropriate State licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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 - Independence Blue Cross and Highmark Blue Shield .

PLAN OF TREATMENT - means 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 Appropriate/Medically Necessary for the Subscriber's diagnosis and condition.

PRESCRIPTION DRUG - means (a) any medication approved by the Plan and which by Federal and or State laws may be dispensed with a Prescription Order, and (b) insulin. The list of covered Prescription Drugs is subject to change from time to time at the sole discretion of the Plan.

PROFESSIONAL PROVIDER - a person or practitioner licensed where required and performing services within the scope of such licensure. Such Professional Providers are:

Certified Registered Nurse	Nurse-midwife
Chiropractor	Optometrist
Dentist	Physical therapist
Independent Clinical Laboratory	Physician
Licensed audiologist	Podiatrist
Licensed speech-language pathologist	Psychologist
Licensed teacher of the hearing impaired	

PROVIDER - a Facility Provider or Professional Provider, licensed where required.

PROVIDER'S REASONABLE CHARGE - for professional services, the charge that the Plan determines is reasonable for Covered Services provided to a Subscriber. The Provider's Reasonable Charge will be the Usual, Customary, and Reasonable (UCR) Allowance as defined in this Booklet, or the charge, whichever is lower.

PSYCHIATRIC HOSPITAL - means a Facility Provider, approved by the Plan, which for compensation from its patients, 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 - means a Psychologist who is licensed in the state in which he practices; or a Psychologist who is otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

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 Plan, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RESIDENTIAL TREATMENT FACILITY - a Facility Provider, licensed and approved by the appropriate government agency and approved by the Plan, which provides treatment for Mental Illness, Serious Mental Illness and for Alcohol and Drug Abuse and Dependency to partial, outpatient or live-in patients who do not require acute Medical Care. This Facility Provider must also meet the Department of Health minimum drug and alcohol standards for client-to-staff ratios and staff qualifications.

SERIOUS MENTAL ILLNESS - means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the diagnostic and statistic manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

SERVICE BENEFIT - a feature whereby Participating Professional Providers agree to accept the Provider's Reasonable Charge as payment in full for Covered Services.

SEVERE SYSTEMIC PROTEIN ALLERGY – 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 - means a unit which is approved by the appropriate Blue Cross Plan and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY - means 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, which:

- A. is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- B. is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- C. is otherwise acceptable to the Plan.

SUBSCRIBER - an enrolled Employee or his Eligible Dependents who have satisfied the specifications under "Who Is Eligible and When?" of the General Information section of this booklet. A Subscriber does not mean any person who is eligible for Medicare except as specifically stated in this booklet.

SUPPLIER - an individual or entity that is in the business of leasing and selling Durable Medical Equipment and supplies. Suppliers include, but are not limited to the following: Durable Medical Equipment suppliers, orthotic and prosthetic suppliers, Pharmacy/Durable Medical Equipment suppliers.

SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures. Payment for Surgery includes an allowance for related inpatient pre-operative and all post-operative care. Treatment of 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 Subscriber.

A. RADIATION THERAPY

The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes, or other radioactive substances regardless of the method of delivery.

B. CHEMOTHERAPY

The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

C. DIALYSIS TREATMENTS

The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. CARDIAC THERAPY

Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

E. 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 locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

F. RESPIRATORY THERAPY

Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

G. OCCUPATIONAL THERAPY

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 and those required by the person's particular occupational role.

H. SPEECH THERAPY

Treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

I. INFUSION THERAPY

Treatment, including but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

USUAL, CUSTOMARY AND REASONABLE (UCR) METHOD – under the UCR methodology, Highmark Blue Shield determines an allowed amount of Covered Services by applying one or more of the following criteria:

The Usual fee is the allowed amount determined by Blue Shield for a Professional Provider based upon that individual provider's charges for the procedure performed..

The Customary fee is the allowed amount determined by Blue Shield by considering relevant professional, economic, and market factors, including but not limited to: the degree of professional involvement, charges of professional providers of the same or similar specialty for the procedure performed, the actual cost of equipment and facilities, or other factors which contribute to the cost of the procedure .

The Reasonable fee is the allowed amount (which may differ from the Usual or Customary allowed amounts) determined by Blue Shield by considering unusual clinical circumstances..

Allowed amounts are updated periodically to respond to changing economic and market circumstances. The timing of updates and methodology employed are subject to approval by the Insurance Department of the Commonwealth of Pennsylvania.