PERSONAL CHOICE HEALTH BENEFITS PLAN

A COMPREHENSIVE MAJOR MEDICAL GROUP BOOKLET-CERTIFICATE

By and Between

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

And

[Account Name]
(Called "the Group")

The Carrier certifies that you (the enrolled Employee and your enrolled eligible Dependents, if any) are entitled to the benefits described in this booklet/certificate, subject to the eligibility and effective date requirements.

This booklet/certificate replaces any and all booklet/certificates previously issued to you under any group contracts issued by the Carrier providing the types of benefits described in this booklet/certificate.

The Contract is between the Carrier and the Contractholder. This booklet/certificate is a summary of the provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

ATTEST:

R. Scott Post
Vice President
Marketing Administration

Comprehensive Major Medical Coverage that utilizes a Preferred Provider Network to maximize benefits while offering covered persons the choice of selecting Non-Preferred Providers, except where specifically prohibited by the contract, subject to a reduction of benefits. This coverage utilizes extensive Precertification and utilization management procedures, which must be followed to maximize benefits and avoid penalties.

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Introduction

This booklet/certificate has been prepared so that you (the enrolled Employee and your enrolled eligible Dependents, if any) may become acquainted with the Personal Choice Health Benefits Plan (this Plan) offered by your employer. Coverage under your employer's Personal Choice Health Benefits Plan is available to those employees who are eligible for the Coverage and enrolled in it. The Personal Choice Health Benefits Plan described in this booklet/certificate is subject to the terms and conditions of the Group Contract issued by QCC Insurance Company (the Carrier).

Benefits will not be available for services to a greater extent or for a longer period than is Medically Necessary/Medically Appropriate, as determined by the Carrier. The amount of benefits for any Covered Service will not exceed the amount charged by the health care provider, and will not be greater than any maximum amount or limit described or referred to in this booklet/certificate.

See "Important Notices".

And, read this booklet/certificate carefully.

Important Notices

Regarding Experimental/Investigative Treatment:

The Carrier does not cover treatment it determines to be Experimental/Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Carrier acknowledges that situations exist when a Covered Person and his or her Physician agree to utilize Experimental/Investigative treatment. If a Covered Person receives Experimental/Investigative treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Carrier to determine whether a treatment is considered Experimental/Investigative. The term "Experimental/Investigative" is defined in the *Defined Terms* section.

Regarding Treatment Which Is Not Medically Appropriate/Medically Necessary:

The Carrier only covers treatment which it determines Medically Appropriate/Medically Necessary. A Member/Contracting Provider accepts the Carrier's decision and contractually is not permitted to bill the Covered Person for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary unless the Member/Contracting Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Carrier, and that the Covered Person will be financially responsible for such services. A Non-Member/Non-Contracting Provider, however, is not obligated to accept the Carrier's determination and the Covered Person may not be reimbursed for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Member/Non-Contracting Provider. You can avoid these charges simply by choosing a Member/Contracting Provider for your care. The term "Medically Appropriate/Medically Necessary" is defined in the *Defined Terms* section.

Regarding Treatment For Cosmetic Purposes:

The Carrier does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Appropriate/Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Carrier acknowledges that situations exist when a Covered Person and his or her Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Covered Person is responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Carrier to determine whether treatment is for cosmetic purposes. The exclusion for services and operations for cosmetic purposes is detailed in the *What Is Not Covered* section.

Regarding Coverage For Emerging Technology:

While the Carrier does not cover treatment it determines to be Experimental/Investigative, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Carrier uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Covered Person, the Carrier researches all scientific information available from these expert sources. Following this analysis, the Carrier makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Covered Person or his or her Provider should contact the Carrier to determine whether a proposed treatment is considered "emerging technology".

Regarding Use Of Non-Preferred Providers

To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the Personal Choice Network or in the Blue Card PPO Program. While Personal Choice has an extensive network, it may not contain every provider that you need. You may obtain Covered Services from Participating Professional Providers or Member Facility Providers (Participating Providers) who are not part of the Personal Choice Network but have agreed to accept contracted rates as payment in full and will not balance bill you. However, you will be subject to Non-Preferred "Out-of-Network" Coinsurance and Deductibles.

In addition, your Personal Choice program allows you to obtain Covered Services from Non-Preferred, Non-Participating Providers. If you use a Non-Preferred, Non-Participating Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance and the balance of the provider's bill. This is true whether you use a Non-Preferred, Non-Participating Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a provider.

The Plan may approve Covered Services provided by a Non-Preferred Provider subject to Preferred "In-Network" cost-sharing, if such cost-sharing is applicable to your program (Copayments, Coinsurance and Deductibles), if you have: (1) sought care from a Preferred Provider in the same specialty as the Non-Preferred Provider; (2) been advised by the Preferred Provider that there are no Preferred Providers that can provide the requested Covered Services; and (3) obtained authorization from the Plan prior to receiving care. The Plan reserves the right to make the final determination whether there is a Preferred Provider that can provide the Covered Services. If the Plan approves the use of a Non-Preferred, Non-Participating Provider, you will be not responsible for the difference between the provider's billed charges and the Plan's payment to the Provider. Applicable program terms including Medical Necessity/Appropriateness and precertification will apply.

REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of "Experimental/Investigative", "cosmetic", or "emerging technology", the Covered Person, or his or her Provider, should contact the Carrier for a coverage determination. That way the Covered Person and the Provider will know in advance if the treatment will be covered by the Carrier.

In the event the treatment is not covered by the Carrier, the Covered Person can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service.

For more information on when to contact the Carrier for coverage determinations, please see the Precertification and Prenotification requirements in the *Managed Care* section.

Defined Terms

The terms below have the following meaning when describing the benefits within this booklet/certificate. They will be helpful to you (the Covered Person) in fully understanding your benefits.

ACCESSIBILITY – the extent to which a member of a Managed Care Organization can obtain from a Preferred Provider available Covered Services at the time they are needed. Accessibility to a Preferred Provider refers to both telephone access and ease of scheduling an appointment.

ACCIDENTAL INJURY - 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 conference 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 AND DEPENDENCY- 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.

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE – Complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM) is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g. homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions which include a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms (e.g. meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance); (c) biologically based therapies using natural substances such as herbs, foods, vitamins or nutritional supplements to prevent and treat illness, (e.g. diets, macrobiotics, megavitamin therapy); (d) manipulative and body-based methods (e.g. massage, equestrian/hippotherapy); and (e) energy therapies, involving the use of energy fields. The energy therapies are of two types: (1) Biofield therapies – intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in or through these fields. Examples include Qi Gong, Reiki, and therapeutic touch. (3) Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which is licensed as required and 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 Carrier 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 this Plan.

ANESTHESIA - consists of the administration of regional 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.

APPEAL – a request by a Covered Person, or the Covered Person's representative or Provider, acting on the Covered Person's behalf upon written consent, to change a previous decision made by the Carrier.

A. **Administrative Appeal** – an Appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative Appeal may present issues related to Medical Necessity or Medical Appropriateness, but these are not the primary issues that affect the outcome of the Appeal.
B. **Medical Necessity Appeal** – a request for the Carrier to change its decision, based primarily on Medical Appropriateness/Medical Necessity, to deny or limit the provision of a Covered Service.
C. **Expedited Appeal** – a faster review of a Medical Necessity Appeal, conducted when the Carrier determines that a delay in decision making would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function.

APPLICANT AND EMPLOYEE/MEMBER - you, the Employee who applies for coverage under this Plan.

APPLICATION AND APPLICATION CARD - the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Carrier.

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 Carrier. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

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

CASE MANAGEMENT – Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person outcomes. Case Management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

CERTIFIED REGISTERED NURSE - a certified registered nurse anesthetist, certified registered nurse practitioner, certified entreostomal 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 or by an anesthesiology group.

COINSURANCE – a type of cost-sharing in which the Covered Person assumes a percentage of the Covered Expense for Covered Services (such as 20 percent).

COMPLAINT – any expression of dissatisfaction, verbal or written, by a Covered Person.

COPAYMENT - a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as a $10 or $15 Copayment per office visit). Copayments, if any, are identified in the *Schedule of Benefits*.

COVERED EXPENSE - refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For services rendered by a Facility Provider, the term "Covered Expense" may not refer to the actual amount(s) paid by the Carrier to the Provider(s). Under the Carrier's contracts, the Carrier pays Facility Providers using bulk purchasing arrangements that permit it to pay less for services and enable it to offer the Personal Choice Discount to its Personal Choice customers. The amount the Carrier pays at the time of any given claim may be more and it may be less than the amount used to calculate the Covered Person's liability. Rather, "Covered Expense" means the following:
   1. For services rendered by a Preferred Facility Provider, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Personal Choice Discount in effect at the time that the services are rendered.
   2. For services rendered by a Non-Preferred Member Facility Provider that has a direct contractual arrangement with the Carrier, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Plan-Wide Discount in effect at the time that the services are rendered.
   3. For services rendered by Non-Preferred Facility Providers that have no contractual arrangement with the Carrier, "Covered Expense" means the lesser of the: (a) Facility Provider's charges, (b) Medicare Allowable Payment, or (c) Reasonable and Customary Charge for the Covered Services.

B. For services rendered by a Professional Provider, "Covered Expense" means the following:
   1. For a Preferred Professional Provider - the rate of reimbursement for Covered services the Professional Provider has agreed to accept as set forth by contract with the Personal Choice Network, or the charge, whichever is less;
   2. For a Participating Professional Provider - the rate of reimbursement for Covered Services will be made in accordance with the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services;
   3. For a Non-Preferred, Non-Participating Professional Provider – the amount as determined by the Carrier's lowest network fee schedule that the Carrier would have paid to a Preferred Professional Provider for the same service, or the charge, whichever is less;

C. For services rendered by Ancillary Providers, "Covered Expense" means the following:
   1. For services rendered by a Preferred Provider, "Covered Expense" means the amount that the Carrier has negotiated with the Preferred Provider as total reimbursement for the Covered Services.
   2. For services rendered by a Non-Preferred Provider, "Covered Expense" means the lesser of the: (a) Provider's charges, (b) Medicare Allowable Payment, or (c) Reasonable and Customary charge for the Covered Services.

COVERED PERSON – an enrolled Employee or his eligible Dependents who have satisfied the specifications of the *Eligibility Under This Plan* section. A Covered Person does not mean any person who is eligible for Medicare except as specifically stated in this booklet/certificate.

COVERED SERVICE - a service or supply specified in this booklet/certificate for which benefits will be provided by the Carrier.

CUSTODIAL 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 skills or 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 Covered Person returns home each evening and for the entire weekend.

DECISION SUPPORT – Decision Support describes a variety of services that help Covered Persons make educated decisions about health care and support their ability to follow their Provider's treatment plan. Some examples of Decision Support services include, but are not limited to, support for major treatment decisions and information about everyday health concerns.

DEDUCTIBLE - a specified amount of Covered Expenses for the Covered Services that is Incurred by the Covered Person before the Carrier will assume any liability.

DETOXIFICATION - 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.

DISEASE MANAGEMENT – a population-based approach to identify Covered Persons who have or are at risk for a particular chronic medical condition, intervene with specific programs of care, and measure and improve outcomes. Disease Management programs use evidence-based guidelines to educate and support Covered Persons and Providers, matching interventions to Covered Persons with the greatest opportunity for improved clinical or functional outcomes. Disease Management programs may employ education, Provider feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist Covered Persons with chronic disease(s). Disease Management interventions are intended to both improve delivery of services in various active stages of the disease process as well as to reduce/prevent relapse or acute exacerbation of the condition.

DURABLE MEDICAL EQUIPMENT - is equipment which meets the following criteria:

A. It is durable and can withstand repeated use;
B. It is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;
C. It generally is not useful to a person in the absence of an illness or injury; and
D. It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to: diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, hospital beds, traction equipment and wheelchairs.

EFFECTIVE DATE - according to the *Eligibility Under This Plan* section, the date on which coverage for a Covered Person begins under this Plan. All coverage begins at 12:01 a.m. on the date reflected on the records of the Carrier.

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 and supplies provided by a Hospital or Facility Provider and/or Professional Provider to a Covered Person in or for an Emergency on an Outpatient basis in a Hospital Emergency Room or Outpatient Emergency Facility.

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 – the provision of nutritional requirements into the alimentary tract.

EXPERIMENTAL/INVESTIGATIVE – a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing Phase I or Phase II Clinical Trials;
B. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
E. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; or The United States Pharmacopeia Drug Information; recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigative.

In addition to the above criteria that pertains strictly to the use of a drug, biological product or device, any drug, biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:
A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.
B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.
E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY PROVIDER - an institution or entity licensed, where required, to provide care. Such facilities include:
A. Ambulatory Surgical Facility
B. Birth Center
C. Free Standing Dialysis Facility
D. Free Standing Ambulatory Care Facility
E. Home Health Care Agency
F. Hospice
G. Hospital
H. Non-Hospital Facility
I. Psychiatric Hospital
J. Rehabilitation Hospital
K. Residential Treatment Facility
L. Short Procedure Unit
M. Skilled Nursing Facility

FAMILY COVERAGE - coverage purchased for the Employee and one or more of the Employee's Dependents.

FREE STANDING AMBULATORY CARE FACILITY - a Facility Provider, 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 Carrier, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

GROUP (or ENROLLED GROUP) - a group of Employees which has been accepted by the Carrier, consisting of all those Applicants whose charges are remitted by the Applicant's Agent together with all the Employees, listed on the Application Cards or amendments thereof, who have been accepted by the Carrier.

HEARING AID – a Prosthetic Device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of: (a) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound to the ear, and (d) a battery for power. A hearing aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a hearing aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely-in-the-canal, and (e) implantable (can be partial or complete). A Hearing Aid is not a cochlear implant.

HOME HEALTH CARE AGENCY - a Facility Provider, approved by the Carrier, 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 - 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 appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

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 Carrier 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;
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 Alcohol or Drug Abuse; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

IDENTIFICATION CARD - the currently effective card issued to the Covered Person by the Carrier which must be presented when a Covered Service is requested.

IMMEDIATE FAMILY - the Covered Person'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 the Covered Person receives the service or supply for which the charge is made.

INDEPENDENT CLINICAL LABORATORY - a laboratory that performs clinical pathology procedure and that is not affiliated or associated with a Hospital, Physician or Facility Provider.

INDEPENDENT REVIEW ORGANIZATION (IRO) – an entity qualified by applicable licensure and/or accreditation standards to act as the independent decision maker on external Medical Necessity appeals requiring evaluation of issues related to Medical Appropriateness/Medical Necessity of a Covered Person's request for Covered Services. The Carrier arranges for the availability of IROs and assigns them to external Medical Necessity appeals. IROs are not corporate affiliates of the Carrier.

INPATIENT ADMISSION (or INPATIENT) – a Covered Person's actual entry into a Hospital, extended care facility or Facility Provider 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 Covered Person is actually discharged from the facility.

INPATIENT CARE FOR ALCOHOL OR DRUG ABUSE - the provision of medical, nursing, counseling or therapeutic services, for Covered Persons suffering from Alcohol or Drug Abuse or dependency, twenty-four (24) hours a day in a Hospital or Non-Hospital Facility, according to individualized treatment plans.

LICENSED CLINICAL SOCIAL WORKER – a social worker who has graduated from a school accredited by the Council on Social Work Education with a Doctoral or Master's Degree and is licensed by the appropriate state authority.

LICENSED PRACTICAL NURSE (LPN) - a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

LIMITING AGE FOR DEPENDENTS – the age as shown in the *Schedule of Benefits*, at which a Dependent child shall be removed from the Employee's coverage. The Limiting Age for covered, unmarried children is shown on the *Schedule of Benefits*.

MAINTENANCE - continuation of care and management of the Covered Person when the maximum therapeutic value of a Medically Appropriate/Medically Necessary treatment plan has 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 and is no longer Medically Appropriate/Medically Necessary. This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

MANAGED CARE ORGANIZATION (MCO) – a generic term for any organization that manages and controls medical service. It includes HMOs, PPOs, managed indemnity insurance programs and managed Blue Cross or Blue Shield programs.

MASTER'S PREPARED THERAPIST (for Mental Health/Psychiatric Services) – a therapist who holds a Master's Degree in an acceptable human services-related field of study and is licensed as a therapist at an independent practice level by the appropriate state authority to provide therapeutic services for the treatment of Mental Health/Psychiatric Services (including treatment of Serious Mental Illness).

MAXIMUM - a limit on the amount of Covered Services that a Covered Person may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance and Copayment amounts paid by Covered Persons for the Covered Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Carrier to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

A. **Benefit Maximum** - the greatest amount of a specific Covered Service that a Covered Person may receive.
B. **Lifetime Maximum** - the greatest amount of Covered Services that a Covered Person may receive in his lifetime.

MEDICAL CARE - services rendered by a Professional Provider within the scope of his 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/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) – an intervention will be covered if it is a Covered Service, not specifically excluded, and Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by the Carrier's medical director or physician designee, it meets all of the following criteria:

A. *It is a "Health Intervention".* A Health Intervention is defined as an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

   A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. *It is the most appropriate supply or level of service, considering potential benefits and harms to the Covered Person.*

C. *It is known to be "effective" in improving "health outcomes".*

Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

1. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered to be new if it is not yet in widespread use for (a) the medical condition, and (b) patient indications being considered.

   "Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

   Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

   New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

2. Existing interventions: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion.

   For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for determinations of Medical Appropriateness/Medical Necessity.

   If no Scientific Evidence is available, professional standards of care should be considered.

   If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion.

   Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

   Existing interventions can meet the contractual definition of Medical Appropriateness/Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. *It is cost effective for this condition compared to alternative interventions, including no intervention.*

"Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this definition of Medical Appropriateness/Medical Necessity. An intervention is covered if: (a) it is a Covered Service; (b) it is not excluded from this Plan; and (c) it is Medically Appropriate/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 FACILITY PROVIDER - a Facility Provider that is not part of the Personal Choice Network but is approved by and has a contractual relationship with the Carrier for the provision of services to Covered Persons.

MENTAL ILLNESS – any of various conditions categorized as mental disorders by the most recent edition of the International Classification of Diseases (ICD), wherein mental treatment is provided by a qualified mental health Provider. For purposes of the Group Contract, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness because the benefit limits for Mental Illness and Serious Mental Illness are separate and not cumulative.

NON-HOSPITAL FACILITY - a Facility Provider, licensed by the Department of Health for the care or treatment of persons suffering from Alcohol or Drug Abuse or dependency, except for transitional living facilities. Non-Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities and Free Standing Ambulatory Care Facilities for Partial Hospitalization Programs.

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

NON-MEMBER FACILITY PROVIDER - a Facility Provider that does not have a contractual relationship with the Carrier for the provision of services to Covered Persons.

NON-PARTICIPATING PROFESSIONAL PROVIDER - a Professional Provider who has not agreed to accept a rate of reimbursement determined by a contract with the Carrier for the provision of Covered Services to Covered Persons.

NON-PREFERRED ANCILLARY PROVIDER – an Ancillary Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NON-PREFERRED FACILITY PROVIDER - a Facility Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NON-PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NON-PREFERRED PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

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 a Covered Person for Covered Services in a Benefit Period. Such expense does not include any Deductible, Penalties, Inpatient or Outpatient mental health/psychiatric care, or Copayment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the *Schedule of Benefits*.

OUTPATIENT CARE (or OUTPATIENT) - medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other Inpatient Facility.

OUTPATIENT DIABETIC EDUCATION PROGRAM – an Outpatient diabetic education program provided by a Preferred Ancillary Provider or a Preferred Facility Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

PARTIAL HOSPITALIZATION - medical, nursing, counseling or therapeutic services 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.

PARTICIPATING PROFESSIONAL PROVIDER – a Professional Provider who has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

PENALTY – a type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified in the *Schedule of Benefits* and explained in detail in the *Managed Care* section.

PERSONAL CHOICE DISCOUNT – the percentage reduction from hospital billed charges for Covered Services that the Carrier passes on to its Personal Choice customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts with Preferred Facility Providers. The amount of the Personal Choice Discount may be changed prospectively from time to time. The Personal Choice Discount is on file with the Pennsylvania Insurance Department.

PERVASIVE DEVELOPMENTAL DISORDERS (PDD) – disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities. Examples are Asperger's syndrome and childhood disintegrative disorder.

PHYSICIAN - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

PLAN OF TREATMENT - a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should include goals and duration of treatment, and be limited in scope and extent to that care which is Medically Appropriate/Medically Necessary for the Covered Person's diagnosis and condition.

PLAN-WIDE DISCOUNT – the percentage reduction from hospital charges for Covered Services that the Carrier passes on to its customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts. The amount of the discount may be changed prospectively from time to time. The amount of the discount is on file with the Pennsylvania Insurance Department.

PRECERTIFICATION (or PRECERTIFY) – prior assessment by the Carrier or designated agent that proposed services, such as hospitalization, are Medically Appropriate/Medically Necessary for a Covered Person and covered by this Plan. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan.

PREFERRED ANCILLARY PROVIDER – an Ancillary Provider that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for the provision of “in-network” Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER - a Facility Provider that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for the provision of “in-network” Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for “in-network” Covered Services rendered to a Covered Person.

PREFERRED PROVIDER – a Facility Provider, Professional Provider or Ancillary Provider that is a member of the Personal Choice Network, authorized to perform specific “in-network” Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) – a type of managed care plan that offers the freedom to choose a physician like a traditional health care plan and provides the physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization). In a PPO, an individual is not required to select a Primary Care Provider to coordinate care, and is not required to obtain referrals to see specialists.

PRENOTIFICATION (or PRENOTIFY) – the requirement that a Covered Person provide prior notice to the Carrier that proposed services, such as maternity care, are scheduled to be performed. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan.

PRIMARY CARE SERVICES – basic, routine medical care traditionally provided to individuals with common illnesses and injuries and chronic illnesses.

PRIMARY CARE PROVIDER – a Professional Provider as listed in the Personal Choice Network directory under "Primary Care Physicians" (General Practice, Family Practice or Internal Medicine), "Obstetricians/Gynecologists" or "Pediatricians".

PRIVATE DUTY NURSING - Medically Appropriate/Medically Necessary Outpatient continuous skilled nursing services provided to a Covered Person by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

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

A. Audiologist
B. Certified Registered Nurse
C. Chiropractor
D. Dentist
E. Independent Clinical Laboratory
F. Licensed Clinical Social Worker
G. Master's Prepared Therapist
H. Nurse Midwife
I. Optometrist
J. Physical Therapist
K. Physician
L. Podiatrist
M. Psychologist
N. Speech-language Pathologist
O. Teacher of the hearing impaired

PROSTHETICS (or PROSTHETIC DEVICES) – devices (except dental prosthetics), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

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

PSYCHIATRIC HOSPITAL - a Facility Provider, approved by the Carrier, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

PSYCHOLOGIST - a Psychologist who is licensed in the state in which he practices; or a Psychologist who is otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

QUALIFYING CLINICAL TRIAL – the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

A. Investigates a service that falls within a benefit category of this Plan;
B. Is not specifically excluded from coverage;
C. Has a therapeutic intent upon enrolled patients with diagnosed disease;
D. Is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;
E. Does not duplicate existing studies;
F. Is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;
G. Is designed and conducted according to appropriate standards of scientific integrity;
H. Complies with Federal regulations relating to the protection of human subjects;
I. Has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;
J. Is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or (2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;

K. Is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider.

In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Carrier as a Qualifying Clinical Trial.

REASONABLE AND CUSTOMARY – means the amount that is the usual or customary charge for the service or supply as determined by the Carrier. The chosen standard is an amount which is most often charged by other Providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual Provider of the service or supply. If no comparison exists, the Carrier determines what is reasonable by the severity and/or complexity of the Covered Person's condition for which the service or supply is provided.

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

RELIABLE EVIDENCE – only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

RESIDENTIAL TREATMENT FACILITY - a Facility Provider, licensed and approved by the appropriate government agency and approved by the Carrier, which provides treatment for Mental Illness and Serious Mental Illness or for Alcohol and Drug Abuse and Dependency to partial, outpatient or live-in patients who do not require acute Medical Care.

ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS – routine costs include: (a) Covered Services under this Plan that would typically be provided absent a Qualifying Clinical Trial; (b) services and supplies required solely for the provision of the Experimental/Investigative drug, biological product, device, medical treatment or procedure; (c) the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and (d) the services and supplies required for the diagnosis or treatment of complications.

Routine costs do not include the Experimental/Investigative drug, biological product, device, medical treatment or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

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 Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

SEVERE SYSTEMIC PROTEIN ALLERGY – means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT - a unit which is approved by the Carrier 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 - 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 Carrier.

SPECIALIST SERVICES – all services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

THERAPY SERVICE - the following services or supplies prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Covered Person:

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

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

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

D. Infusion Therapy - treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

E. Occupational Therapy - medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

F. Orthoptic/Pleoptic Therapy - medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from vision disorder, eye surgery, or injury. Treatment involves a program which includes evaluation and training sessions.

G. Physical Therapy - medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

H. Pulmonary Rehabilitation Therapy - multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

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

J. Speech Therapy - medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

TOTAL DISABILITY (or TOTALLY DISABLED) – means that a covered Employee, due to illness or injury, cannot perform any duty of his or her occupation or any occupation for which the Employee is, or may be, suited by education, training and experience, and the Employee is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Totally Disabled person must be under the regular care of a Physician.

URGENT CARE – Medically Appropriate/Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or-limb threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Covered Person's health if treatment were delayed.

Your Personal Choice Network Plan

Your Personal Choice Network Plan (this Plan) is a program, which allows you (a Covered Person) to maximize your health care benefits by utilizing the Personal Choice Preferred Provider Organization's Providers. These Providers are called "Preferred Providers" in this booklet/certificate. You may think of them as "In-Network Providers". Preferred Providers are doctors, Hospitals and other health care professionals and institutions that are part of the Personal Choice Network. Personal Choice Preferred Provider benefits are delivered through a specially selected, highly managed network of cost-effective Providers to ensure quality care. The Personal Choice Network includes Hospitals, Primary Care Providers and specialists, and a wide range of Ancillary Providers, including suppliers of Durable Medical Equipment, Hospice care and Home Health Care Agencies, Skilled Nursing Facilities, Free Standing Dialysis Centers and Ambulatory Surgical Facilities.

When you receive health care through a Provider that is a member of the Personal Choice Network, you are assured of limited out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. You may have to reach a Deductible before receiving benefits and you may be required to file a claim form.

A directory of the Preferred Providers who belong to the Personal Choice Network is available to you upon request. It will identify the Professional Providers who have agreed to become Preferred Professional Providers and will also identify the Hospitals in the Network with which the Preferred Professional Providers are affiliated. Also included in the directory is a listing of the Ancillary Providers affiliated with the Personal Choice Network. The directory is updated periodically throughout the year, and the Carrier reserves the right to add or delete Physicians and/or Hospitals at any given time. It is important to know that continued participation of any one doctor, Hospital or other Provider cannot be guaranteed. For information regarding Providers that participate in the Personal Choice Network, call the Carrier's Health Resource Center at 1-800-ASK BLUE.

The Carrier covers only care that is Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient department.

Some of the services you receive through this Plan must be Precertified before you receive them, to determine whether they are Medically Appropriate/Medically Necessary. Failure to Precertify Non-Preferred services, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews whether certain procedures/admissions are Medically Appropriate/Medically Necessary. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. The latest innovations in health care enable doctors to provide services, once provided exclusively in an Inpatient setting, in many different settings – such as an Outpatient department of a Hospital or a doctor's office.

When you seek medical treatment that requires Precertification, you are not responsible for obtaining the Precertification if treatment is provided by a Personal Choice Network Provider. In addition, if the Personal Choice Network Provider fails to obtain a required Precertification of services, you will be held harmless from any associated financial Penalties assessed by this Plan as a result. If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

A. Acknowledge this in writing.
B. Request to have services provided.
C. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a BlueCard provider of another Blue Cross or Blue Shield plan, you are responsible for initiating the Precertification process. You should instruct your Provider to call the Precertification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to Precertify required services will result in a reduction of benefits payable to you.

A. Payment Of Providers

1. Network Provider Reimbursement

Personal Choice reimbursement programs for health care Providers are intended to encourage the provision of quality, cost-effective care for Personal Choice members. Set forth below is a general description of Personal Choice reimbursement programs, by type of Personal Choice Network health care Provider.

Please note that these programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care Provider is compensated, please speak with your healthcare provider directly or contact the Carrier's Member Services Department.

a. Physicians

Personal Choice Network Physicians, including Primary Care Provider (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Carrier's Personal Choice fee schedule for the specific medical services that the Physician performs.

b. Institutional Providers

Hospitals: For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

The Carrier implemented a quality incentive program with a few Hospitals. This program provides increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

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

Ambulatory Surgical Facilities (ASFs): Most ASFs are paid specific rates based on the type of Covered Service performed. For a few services, some ASFs are paid based on a percentage of billed charges.

c. Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with

individual physicians to provide medical services. These groups are paid as described in the physicians reimbursement section outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

d. Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment Providers, laboratory Providers, Home Health Care Agencies, and mental health/psychiatric care and Alcohol and Drug Abuse Providers are paid on the basis of fee-for-service payments according to the Carrier's Personal Choice fee schedule for the specific Covered Services performed. In some cases, such as for mental health/psychiatric care and Alcohol and Drug Abuse benefits, one (1) vendor arranges for all such services through a contracted set of providers. The Carrier reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Blue Cross has less than a three percent ownership interest in this mental health/psychiatric care and Alcohol and Drug Abuse vendor.

e. Hospitalists

The Carrier currently does not have a hospitalist program in place but is considering implementing such a program in the future. The Carrier continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing Emergency room consultation and Inpatient management services.

2. Payment Methods

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

a. Facility Providers

(1) Preferred Facility Providers

Preferred Facility Providers are members of the Personal Choice Network and have a contractual arrangement with the Carrier for the provision of services to Covered Persons. Benefits will be provided as specified in the *Schedule of Benefits* for services which have been performed by a Preferred Facility Provider. The Carrier will compensate Preferred Facility Providers in accordance with the contracts entered into between such Providers and the Carrier. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

(2) Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the Personal Choice Network. The Carrier may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network. Non-Preferred Member Facility Providers that have contracts with the Carrier will be compensated in accordance with the contracts entered into between such Providers and the Carrier.

A Non-Preferred Non-Member Facility Provider is a Facility Provider which does not belong to the Personal Choice Network, nor does it have a contract with the Carrier. The Carrier will provide benefits at a Non-Preferred Non-Member Provider at the Non-Preferred coinsurance level specified in the *Schedule of Benefits*.

If the Carrier determines that Covered Services were for Emergency Care as defined herein, the Covered Person normally will not be subject to the cost-sharing Penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Carrier.

The Carrier will provide benefits for the Covered Expenses incurred for certain medical services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred Facility Provider or a Member Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Carrier.

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

b. Professional Providers

(1) Preferred and Participating Professional Provider Reimbursement

The Carrier is authorized by the Covered Person to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this Plan. Preferred and Participating Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred and Participating Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost-sharing features as specified under this Plan. The Covered Person is responsible within sixty (60) days of the date in which the Carrier finalizes such services to pay, or make arrangements to pay, such amounts to the Preferred and Participating Professional Provider.

Benefit amounts, as specified in the *Schedule of Benefits* of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to the Carrier for determination. The decision of the Carrier shall be final.

(2) Non-Preferred Professional Provider Reimbursement

When Covered Services are performed by a Non-Preferred Professional Provider, the Carrier will make payment to the Covered Person, subject to any applicable Coinsurance or other cost-sharing Penalty on services by Non-Preferred Professional Providers. When a Covered Person seeks care from a Non-Preferred Participating Professional Provider, payment will be made in accordance with the rate of reimbursement determined by the contract between the Professional Provider and the Carrier. When a Covered Person seeks care from a Non-Preferred, Non-Participating Professional Provider, payment will be the amount as determined by the Carrier's lowest network fee schedule that the Carrier would have paid to a Preferred Professional Provider for the same service, or the charge, whichever is less. Accordingly, when a Covered Person seeks care from Non-Preferred, Non-Participating Professional Providers, any difference between the Non-Preferred Professional Provider's charge and the Carrier's payment shall be the personal responsibility of the Covered Person. This amount may be significant.

If the Carrier determines that services were performed during an Emergency, the Covered Person will not be subject to the cost-sharing features ordinarily applicable to Covered Services rendered by Non-Preferred Professional Providers.

Once Covered Services are rendered by a Professional Provider, the Carrier will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. The Carrier will have no liability to any person because of its rejection of the request.

c. Ancillary Providers

(1) Preferred Ancillary Providers

Preferred Ancillary Providers include members of the Personal Choice Network that have a contractual relationship with the Carrier for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the *Schedule of Benefits* for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. The Carrier will compensate Preferred Ancillary Providers in the Personal Choice Network in accordance with the contracts entered into between such Providers and the Carrier. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Ancillary Provider.

(2) Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the Personal Choice Network. Benefits will be provided to the Covered Person at the Non-Preferred coinsurance level specified in the *Schedule of Benefits*. The Covered Person will be penalized by the application of higher cost-sharing as detailed in the *Schedule of Benefits*.

d. Assignment of Benefits to Providers

The right of a Covered Person to receive benefit payments under this Plan 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 coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under this Plan, as required by law.

B. BlueCard PPO Program

As a Covered Person under this Personal Choice Health Benefits Plan, the Carrier is able to provide you with access to the BlueCard PPO Program. If you travel outside the Carrier's geographic service area and receive Covered Services from a Provider that is outside of the Personal Choice Network, you still can receive the Preferred level of benefits if the Provider participates in the BlueCard PPO Program. If Precertification is required for the Covered Service, however, you are responsible for ensuring that the Provider obtain all required certifications.

Under this Personal Choice Health Benefits Plan, "Preferred Provider" is defined to be a Facility Provider, Professional Provider or Ancillary Provider that is a member of the Personal Choice Network, authorized to perform specific Covered Services at the Preferred level of benefits. For purposes of giving a Covered Person access to the BlueCard PPO Program, a "Preferred Provider" is also a Facility Provider, Professional Provider or Ancillary Provider that is: (1) located outside of the Carrier's geographic area, (2) is authorized to perform specific Covered Services at the Preferred level of benefits, (3) has agreed to render Covered Services to Covered Persons at the Preferred level of benefits for a price or fee determined in advance under an agreement with another Blue Cross and Blue Shield Plan, and (4) does not have such an agreement with the Carrier. This type of Preferred Provider is referred to as a "BlueCard PPO Provider".

When you obtain health care services through BlueCard outside the geographic area the Carrier serves, the amount you pay for Covered Services is calculated on the lower of:

1. The billed charges for your Covered Services, or
2. 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 Plan. 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 Plan to use a basis for calculating your 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 in this section or require a surcharge, the Carrier would then calculate your liability for any covered health care services in accordance with the applicable Host Plan state statute in effect at the time you received your care.

C. Deductible

If you choose to utilize a Non-Preferred Provider, you must pay a portion of your covered medical expenses before the Carrier begins to pay for benefits. A Deductible must be met each Benefit Period before payment will be made for most Covered Services. See the *Schedule of Benefits* section for the Deductible amount and the services to which the Deductible is applicable.

Expenses incurred for Non-Preferred Services in the last three (3) months of a Benefit Period which were applied to that year's Non-Preferred Deductible will be applied to the Deductible for the next Benefit Period.

No more than three (3) times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. However, no family member may contribute more than the individual Deductible amount.

D. Coinsurance

Coinsurance is a percentage of the Covered Expenses that must be paid by you or your covered Dependents; it is applied after the Deductible, if any, is met. Coinsurance is applied to most Covered Services, but not to Covered Services that require you to pay a Copayment amount. See the *Schedule of Benefits* for specific Coinsurance amounts.

Limits on Coinsurance Liability

There is a Maximum placed on the amount of Coinsurance which you are required to pay each Benefit Period. This Maximum is called your "Out-of-Pocket Coinsurance Limit ". See the *Schedule of Benefits* for the Out-of-Pocket Coinsurance Limit amounts.

When the Non-Preferred Out-of-Pocket Limits are reached, the Carrier will pay 100% of the Covered Expenses for Non-Preferred services Incurred during the balance of the Benefit Period. There is an individual Out-of-Pocket Limit and a family Out-of-Pocket Limit that applies to Non-Preferred Covered Services. In meeting the family Out-of-Pocket Limit, not more than three (3) times the individual Out-of-Pocket Limit amount must be satisfied by the family members enrolled under one (1) Family Coverage before the Coinsurance is increased to 100% for Covered Services for the remainder of the Benefit Period. However, no family member may contribute more than one individual amount toward the family Out-of-Pocket Limit.

Inpatient and Outpatient Mental Health/Psychiatric Care, your Deductible, if any, and any other Copayments and Penalties do not count toward the Out-of-Pocket Limits.

E. Copayment

Copayment is a type of cost-sharing in which the Covered Person pays a flat dollar amount each time an applicable Covered Service is provided. See the *Schedule of Benefits* for Copayment amounts for specific Covered Services. If the Provider's allowable charge for a Covered Service is less than the Copayment amount, you are only responsible to pay the Provider's allowable charge. In such a case, the Provider is required to remit any overpayment directly to you.

F. Lifetime Maximum

There is a Lifetime Maximum for all Non-Preferred services. Benefits for Non-Preferred care will cease after the Non-Preferred Lifetime Maximum is reached.

See the *Schedule of Benefits* for Lifetime Maximum amount. Amounts applied to the Covered Person's Lifetime Maximum are not restorable.

G. How To File A Claim

You are never required to file a claim when Covered Services are provided by Preferred Providers. When you receive care from a Non-Preferred Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the Carrier's Member Services Department at the number listed on the back of your Identification Card, and a claim form will be sent to you. Fill out the claim form and return it with your itemized bills to the Carrier at the address listed on the claim form no later than twenty (20) days after completion of the Covered Services. The claim should include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, your benefits will not be reduced, but in no event will the plan be required to accept the claim more than two (2) years after the end of the Benefit Period in which the Covered Services are rendered.

Eligibility Under The Plan

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

Eligible Person

You are eligible to be covered under this Plan if you are determined by the Group as eligible to apply for coverage and sign the Application.

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

Eligible Dependent

Your family is eligible for coverage (Dependent coverage) under this Plan when you are eligible for Employee coverage. An eligible Dependent is defined as your spouse under a legally valid existing marriage, your unmarried child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. The limiting age for covered, unmarried children or for a student enrolled full-time in an Accredited Educational Institution is shown on the *Schedule of Benefits*.

A full-time student who is eligible for coverage under this plan who is (1) a member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or (2) a member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch.76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

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

As proof of eligibility, the Employee must submit a form to the Carrier approved by the Department of Military & Veterans Affairs (DMVA): (1) notifying the Carrier that the Dependent has been placed on active duty; (2) notifying the Carrier that the Dependent is no longer on active duty; (3) showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after his release from active duty.

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

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

A newly acquired Dependent shall be eligible for coverage under this Plan on the date the Dependent is acquired provided that you apply to the Carrier for addition of the Dependent within thirty-one (31) days after the Dependent is acquired and you make timely payment of the appropriate rate. If Application is made later than thirty-one (31) days after the Dependent is acquired, coverage shall become effective on the first billing date following thirty (30) days after your Application is accepted by the Carrier.

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

No Dependent may be eligible for coverage as a Dependent of more than one (1) Member of the Enrolled Group. No individual may be eligible for coverage hereunder as a Member and as a Dependent of a Member at the same time.

Description of Benefits

Subject to the exclusions, conditions and limitations of this Plan, a Covered Person is entitled to benefits for the Covered Services described in this *Description of Benefits* section during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. These amounts and percentages, and other cost-sharing requirements are specified in the *Schedule of Benefits*.

Covered Services may be provided by either a Preferred or Non-Preferred Provider. However, the Covered Person will maximize the benefits available when Covered Services are provided by a Provider that belongs to the Personal Choice Network (a Preferred Provider) and has a contract with the Carrier to provide services and supplies to the Covered Person. The Covered Person will be held harmless for out of network differentials if: a Preferred Provider fails to provide written notice to the Covered Person of the Provider's Non-Preferred status for certain services; or, a Preferred Provider provides a written order for certain services to be performed by a Preferred Provider that has Non-Preferred status for those services and that Provider performs such service. The *Your Personal Choice Network Plan* section provides more detail regarding Preferred and Non-Preferred Providers, the Personal Choice Network, and the reimbursement of Covered Services provided by Facility Providers and Professional Providers.

Some Covered Services must be Precertified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medical Appropriateness/Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the *Your Personal Choice Network Plan* and the *Managed Care* sections. Covered Services that require Precertification, and any Penalty for failure to obtain a Precertification, are specified on the *Schedule of Benefits*.

Primary And Preventive Care

A Covered Person is entitled to benefits for Primary Care and "Preventive Care" Covered Services when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the *Schedule of Benefits*.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Covered Person has no symptoms of disease. Services performed to treat an illness or injury are not covered as Preventive Care under this benefit.

The Carrier periodically reviews the schedule of Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of Covered Services are subject to change. The Carrier reserves the right to modify the schedule at any time after written notice of the change has been given to the Covered Person.

A. Office Visits

Medical care visits for the examination, diagnosis and treatment of an illness or injury by a Primary Care Provider. For the purpose of this benefit, "Office Visits" include medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

B. Pediatric Preventive Care

Pediatric Preventive Care includes the following:

1. Physical Examination, Routine History, Routine Diagnostic Tests. Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e., 2-3 months), the dash indicates that coverage is available for one service from two (2) months through three (3) months of age.

   Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:
   - Eight (8) exams between the ages of 0-24 months within the following age ranges:

0-1 month	9-11 months
2-3 months	12-14 months
4-5 months	15-17 months
6-8 months	18-24 months
   - One (1) exam every calendar year between two (2) and seventeen (17) years of age

2. Blood Lead Screening. This blood test detects elevated lead levels in the blood. Children are covered for:
   - One (1) test between 9-12 months of age
   - One (1) test at twenty-four (24) months of age

3. Hemoglobin/Hematocrit. This blood test measures the size, shape, number and content of red blood cells. Children are covered for:
   - One (1) test between 0-12 months of age
   - One (1) test between one (1) and four (4) years of age
   - One (1) test between five (5) and twelve (12) years of age
   - One (1) test between thirteen (13) and seventeen (17) years of age

4. Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.

5. Urinalysis. This test detects numerous abnormalities. Children are covered for:
   - One (1) test every 365 days between 0-24 months of age
   - One (1) test every calendar year between two (2) and seventeen (17) years of age

C. Pediatric Immunizations

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the 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 are limited to Covered Persons under twenty-one (21) years of age.

D. Adult Preventive Care

1. Physical Examination, Routine History. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons eighteen (18) years of age or older in accordance with the following schedule:
   - One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
   - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
   - One (1) examination every calendar year, beginning at forty (40) years of age

2. Adult Tetanus Toxoid (TD). This immunization provides immunity against tetanus and diphtheria.
   - One (1) test every ten (10) calendar years, beginning at eighteen (18) years of age

3. Blood Cholesterol Test. This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.
   - One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
   - One (1) examination every calendar year, beginning at forty (40) years of age

4. Complete Blood Count (CBC). This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.
   - One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
   - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
   - One (1) test every calendar year, beginning at forty (40) years of age

5. Fecal Occult Blood Test. This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.
   - One (1) test every calendar year, beginning at fifty (50) years of age

6. Flexible Sigmoidoscopy. This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.
   - One (1) test every three (3) calendar years, beginning at fifty (50) years of age

7. Influenza Vaccine. This vaccine provides immunization against influenza type A and B viruses.
   - One (1) vaccine every calendar year, beginning at eighteen (18) years of age

8. Pneumococcal Vaccine. This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.
   - One (1) vaccine every five (5) calendar years, beginning at sixty-four (64) years of age

9. Prostate Specific Antigen (PSA). This blood test may be used to detect tumors of the prostate.
   - One (1) test every calendar year, beginning at fifty (50) years of age

10. Routine Colonoscopy. This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.
    - One (1) test every ten (10) calendar years, beginning at fifty (50) years of age

11. Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the adult has ever been immunized.
    - One (1) test and immunization between eighteen (18) and forty-nine (49) years of age

12. Thyroid Function Test. This test detects hyperthyroidism and hypothyroidism.
    - One (1) series of tests every calendar year, beginning at eighteen (18) years of age

13. Urinalysis. This test detects numerous abnormalities.
    - One (1) test every calendar year, beginning at eighteen (18) years of age

14. Varicella Vaccine. This vaccine is recommended for women of childbearing age who have not been previously exposed to the chicken pox virus.
    - One (1) immunization for women between eighteen (18) and forty-nine (49) years of age

15. Fasting Blood Glucose Test. This test is used for detection of diabetes
    - One (1) test every three (3) years, beginning at age forty-five (45).

16. Abdominal Aortic Aneurysm screening. One (1) test per lifetime is recommended for men with a smoking history.
    - One (1) ultrasound for men between sixty-five (65) and seventy-five (75) years of age.

17. Benefits are also payable for certain immunizations provided to Covered Persons determined to be at "high risk" as determined by the Carrier.

E. Routine Gynecological Examination, Pap Smear

Female Covered Persons are covered for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

F. Mammograms

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

G. Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

- One screening test every two calendar years beginning at age 65

Inpatient Benefits

A Covered Person is entitled to benefits for Covered Services while an Inpatient in a Facility Provider when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the *Schedule of Benefits*.

A. Hospital Services

1. Ancillary Services

Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including, but not limited to, the following:

a. Meals, including special meals or dietary services as required by the Covered Person's condition;
b. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
c. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
d. Oxygen and oxygen therapy;
e. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
f. Cardiac Rehabilitation Therapy, Chemotherapy, Dialysis, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation Therapy, Radiation Therapy, respiratory therapy, and Speech Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
g. All drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;
h. Use of special care units, including, but not limited to, intensive or coronary care; and
i. Pre-admission testing.

2. Room and Board

Benefits are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

a. An average semi-private room, as designated by the Hospital; or a private room, when designated by the Carrier as semi-private for the purposes of this plan in Hospitals having primarily private rooms;
b. A private room, when Medically Appropriate/Medically Necessary;
c. A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
d. A bed in a general ward; and
e. Nursery facilities.

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

A Copayment may apply to a Preferred Inpatient Admission, if specified in the *Schedule of Benefits*. For purposes of calculating the total Copayment due, an admission occurring within ninety (90) days of discharge from a previous admission shall be treated as part of the previous admission

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

Days available shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (a) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (b) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

B. Medical Care

Medical Care rendered by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

1. Concurrent Care

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility 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 Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

2. Consultations

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider's rules and regulations. Benefits are limited to one (1) consultation per consultant during any Inpatient confinement.

C. Skilled Nursing Care Facility

Benefits are provided for a Skilled Nursing Care Facility, when Medically Appropriate/Medically Necessary as determined by the Carrier, up to the Maximum days specified in the *Schedule of Benefits*. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility.

A Copayment may apply to a Preferred Inpatient Admission, if specified in the *Schedule of Benefits*. For purposes of calculating the total Copayment due, an admission occurring within ninety (90) days of discharge from a previous admission shall be treated as part of the previous admission.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

Days available shall be allowed only during uninterrupted stays in a Skilled Nursing Care Facility. Benefits shall not be provided: (a) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (b) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

Medically Appropriate/Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the *Schedule of Benefits*.

No Skilled Nursing Care Facility benefits are payable:

1. When confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;
2. For the treatment of Alcohol and Drug Abuse or dependency, and mental illness; or
3. After the Covered Person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.

Inpatient/Outpatient Benefits

A Covered Person is entitled to benefits for Covered Services either while an Inpatient in a Facility Provider or on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the *Schedule of Benefits*.

A. Blood

Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage or transfusion - i.e., an individual having his own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for whole Blood, Blood plasma and Blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

B. Hospice Services

When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six (6) months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with a terminal illness rather than cure it. Hospice Care provides services to make the Covered Person as comfortable and pain-free as possible. When a Covered Person elects to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice Care at any time.

Respite Care: When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person's home. Up to seven (7) days of such care every six (6) months will be covered.

Benefits for Covered Hospice Services shall be provided until the earlier of the Covered Person's death or discharge from Hospice Care.

Special Hospice Services Exclusions: No Hospice Care benefits will be provided for:

1. Services and supplies for which there is no charge;
2. Research studies directed to life lengthening methods of treatment;
3. Services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
4. Care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

C. Maternity/OB-GYN/Family Services

1. Maternity/Obstetrical Care

Services rendered in the care and management of a pregnancy for a Covered Person are a Covered Expense under this Plan as specified in the *Schedule of Benefits*. Prenotification of maternity care should occur within one (1) month of the first prenatal visit to the Physician or midwife. Benefits are payable for: (1) facility services provided by a Hospital or Birth Center; and (2) professional services performed by a Professional Provider or certified nurse midwife.

Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the Carrier as provided for in the *Managed Care* section.

In the event of early post-partum discharge from an Inpatient Admission, benefits are provided for Home Health Care as provided for in the Home Health Care benefit.

2. 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 a Covered Person are a Covered Expense under this Plan.

3. Newborn Care

The newborn child of a Covered Person shall be entitled to benefits provided by this Plan from the date of birth up to a maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond thirty-one (31) days under conditions specified in the *Eligibility Under This Plan* section.

4. Artificial Insemination

Services performed by a Professional Provider for the promotion of fertilization of a female recipient's own ova (eggs) by the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying simple sperm preparation, sperm washing and/or thawing.

D. Mental Health/Psychiatric Care

Benefits for the treatment of Mental Illness and Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as Mental Health/Psychiatric Care are subject to the Mental Health/Psychiatric Care limitations shown in the *Schedule of Benefits*. When a

Provider renders Medical Care, other than Mental Health/Psychiatric Care, for a Covered Person with Mental Illness and Serious Mental Illness, payment for such Medical Care will be based on the Medical Benefits available and will not be subject to the Mental Health/Psychiatric Care limitations.

Preauthorization information must be submitted by the Provider to the Carrier for review and evaluation so a Plan of Treatment may be Precertified for the Covered Person. Precertification must be obtained for all treatment, other than Emergency Care in order to assure the Medical Appropriateness/Medical Necessity of the proposed treatment based on the nature and severity of the Covered Person's condition. A personal assessment by a Preferred Professional Provider will be provided by the Carrier at no cost to the Covered Person to accommodate the Precertification process. Emergency Care is exempt from the requirements for Precertification and will be considered Preferred Care. However, Emergency admissions or services must be reviewed and authorized within two (2) business days of the admission or services, or as soon as possible as determined by the Carrier.

1. Inpatient Treatment

   Benefits are provided, subject to the Benefit Period limitations stated in the *Schedule of Benefits*, for an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be received from a Preferred Facility Provider and Inpatient visits for the treatment of mental illness and Serious Mental Illness must be performed by a Preferred Professional Provider.

   Covered Services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing and psychopharmacologic management.

   A Copayment may apply to a Preferred Inpatient Admission, if specified in the *Schedule of Benefits*. For purposes of calculating the total Copayment due, any admission occurring within ninety (90) days of discharge from any previous admission shall be treated as part of the previous admission.

2. Outpatient Treatment

   Benefits are provided, subject to the Benefit Period limitations shown in the *Schedule of Benefits*, for Outpatient treatment of Mental Illness and Serious Mental Illness. Outpatient Mental Health/Psychiatric Care shall be covered for the full number of Outpatient session visits or an equivalent number of Partial Hospitalization visits per Benefit Period. For treatment of mental illness, the Covered Person may trade off: (a) on a one (1) for two (2) basis, Inpatient days for additional separate Partial Hospitalization services; or (b) on a one (1) for four (4) basis, Inpatient days for additional Outpatient visits. See the *Schedule of Benefits* for limits on the number of Inpatient days that may be exchanged in any Benefit Period. For treatment of Serious Mental Illness, the Covered Person may trade on a one (1) for two (2) basis, Inpatient days for additional Outpatient Partial Hospitalization days/Outpatient session visits. For maximum benefits, treatment must be performed by a Preferred Professional Provider/Preferred Facility Provider.

   Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, Licensed Clinical Social Worker visits, Master's Prepared Therapist visits, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

3. Benefits are not payable for the following services:

   a. Vocational or religious counseling;
   b. Activities that are primarily of an educational nature;
   c. Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy, and obesity control therapy.

4. Benefit Period Maximums for Mental Health/Psychiatric Care

   All Inpatient and Outpatient Mental Health/Psychiatric Care for both mental illness and Serious Mental Illness are covered up to the Maximum day and visit limitation amounts per Benefit Period specified in the *Schedule of Benefits*. Non-Preferred Benefit Period maximums are part of, not separate from, Preferred Benefit Period maximums.

E. Routine Costs Associated With Qualifying Clinical Trials

Benefits are provided for Routine Costs Associated With Participation in a Qualifying Clinical Trial (see the *Defined Terms* section). To ensure coverage, the Carrier must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial.

F. Surgical Services

Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. 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: (1) the surgical procedure performed in connection with the initial and subsequent, insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (2) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Covered surgical procedures shall include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

1. Hospital Admission for Dental Procedures or Dental Surgery

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. 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.

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Appropriate/Medically Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Plan will be covered during such a confinement.

2. Oral Surgery

Benefits will be payable for Covered Services provided by a Professional Provider and/or Facility Provider for:

a. Orthognathic surgery – surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:

(1) The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.

(2) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.

(3) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.

b. Other oral surgery - defined as surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Benefits will be provided only for:

(1) Surgical removal of impacted teeth which are partially or completely covered by bone;

(2) The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and

(3) Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

3. Assistant at Surgery

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant at Surgery only if an intern, resident, or house staff member is not available.

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. 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.

4. Anesthesia

Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider (except an Obstetrician providing Anesthesia during labor and delivery and an oral surgeon providing services otherwise covered under this booklet/certificate).

5. Second Surgical Opinion (Voluntary)

Consultations for Surgery to determine the Medical Appropriateness/Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an emergency or life threatening nature. Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

G. Transplant Services

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

1. When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this Plan.

2. When only the recipient is a Covered Person, both the donor and the recipient are entitled to the benefits of this Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or coverage by the Carrier or any government program. Benefits provided to the donor will be charged against the recipient's coverage under this Plan.

3. When only the donor is a Covered Person, no benefits will be provided for Transplant Services.

4. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

H. Treatment for Alcohol or Drug Abuse and Dependency

Alcohol or Drug Abuse and dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal.

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and dependency provided by a Hospital or Facility Provider, subject to the Maximums shown in the *Schedule of Benefits*, according to the provisions outlined below. For maximum benefits, treatment must be received from a Preferred Provider.

Pre-authorization information must be submitted by the Provider to the Carrier for review and evaluation so a Plan of Treatment may be Precertified for the Covered Person. Precertification must be obtained for all treatment, other than Emergency Care in order to assure the Medical Appropriateness/Medically Necessity of the proposed treatment based on the nature and severity of the Covered Person's condition. A personal assessment by a Preferred Professional Provider will be provided by the Carrier at no cost to the Covered Person to accommodate the Precertification process. Emergency Care is exempt from the requirements for Precertification. However, Emergency admissions or services must be reviewed and authorized within two (2) business days of the admission or services, or as soon as possible as determined by the Carrier.

Precertification must be obtained for all Plans of Treatment. Emergency admissions must be certified within two (2) days, or as soon as possible as determined by the Carrier.

1. Inpatient Treatment

a. Inpatient Detoxification

Inpatient Covered Services for Detoxification shall be covered for seven (7) days per admission for Detoxification with a Lifetime Maximum of four (4) admissions for Detoxification per Covered Person.

Covered Services include:
(1) Lodging and dietary services;
(2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
(3) Diagnostic x-rays;
(4) Psychiatric, psychological and medical laboratory testing;
(5) Drugs, medicines, use of equipment and supplies.

A Copayment may apply to a Preferred Inpatient Admission, if specified in the *Schedule of Benefits*. For purposes of calculating the total Copayment due, any admission occurring within ninety (90) days of discharge from any previous admission shall be treated as part of the previous admission.

b. Hospital and Non-Hospital Residential Treatment

Hospital or Non-Hospital Residential Treatment of Alcohol or Drug Abuse and dependency shall be covered on the same basis as any other illness covered under this Plan, but services are limited to thirty (30) days per Benefit Period.

The lifetime Maximum number of days per Covered Person for this benefit is shown in the *Schedule of Benefits*.

Covered services include:
(1) Lodging and dietary services;
(2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
(3) Rehabilitation therapy and counseling;
(4) Family counseling and intervention;
(5) Psychiatric, psychological and medical laboratory testing;
(6) Drugs, medicines, use of equipment and supplies.

A Copayment will apply to all Preferred Inpatient admissions, as specified in the *Schedule of Benefits*. For purposes of calculating the total Copayment due, any admission occurring within ninety (90) days of discharge from any previous admission shall be treated as part of the previous admission.

2. Outpatient Treatment

Outpatient Alcohol or Drug Services shall be covered for sixty (60) full Outpatient session visits or an equivalent number of Partial Hospitalization visits per Benefit Period. Thirty (30) of the sixty (60) separate sessions of Outpatient or Partial Hospitalization services may be exchanged on a two (2) to one (1) basis to receive up to fifteen (15) more days of Non-Hospital Residential Alcohol or Drug Abuse Treatment (i.e., the Covered Person may trade off on a two (2) for one (1) basis up to thirty (30) separate sessions of Outpatient services per Benefit Period in order to receive up to fifteen (15) additional days of Hospital and Non-Hospital Residential Alcohol or Drug Abuse Treatment days). Any benefits exchanged or traded off under terms of this provision are subject to, and do not increase, the overall Lifetime Maximum.

The lifetime Maximum number of days per Covered Person for this benefit is shown in the *Schedule of Benefits*.

Covered services include:

a. Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification;
b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
c. Rehabilitation therapy and counseling;
d. Family counseling and intervention;
e. Psychiatric, psychological and medical laboratory testing;
f. Drugs, medicines, use of equipment and supplies.

Outpatient Benefits

A Covered Person is entitled to benefits for Covered Services on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the *Schedule of Benefits*.

A. Ambulance Services

Benefits are provided for ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Carrier, for transportation in a specially designed and equipped vehicle used only to transport the sick or injured, but only when:

1. the vehicle is licensed as an ambulance where required by applicable law;
2. the ambulance transport is appropriate for the patient's clinical condition;
3. the use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would be contraindicated (i.e. would endanger the patient's medical condition); and,
4. the ambulance transport satisfies the destination and other requirements stated below in either "A. For Emergency Ambulance transport" or "B. For Non-Emergency Ambulance transport".

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

A. For Emergency Ambulance transport

The ambulance must be transporting the Covered Person from the Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital or other Emergency Care Facility that can provide the Medically Appropriate/Medically Necessary Covered Services for the Covered Person's condition.

B. All non-emergency ambulance transports must be Precertified by the Carrier to determine Medical Appropriateness/Medical Necessity which includes specific origin and destination requirements specified in the Company's policies.

Non-emergency ambulance transports are not provided for the convenience of the Covered Person, the family, or the Provider treating the Covered Person.

B. 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 Covered Person 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 Covered Person 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 Covered Person is willing to participate in a Day Rehabilitation Program; and

4. The Covered Person's family must be able to provide adequate support and assistance is the home and must demonstrate the ability to continue the rehabilitation program in the home.

C. 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 Covered Person 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 Covered Person's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Preferred Facility Provider or a Preferred Ancillary Provider. 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 Carrier. These requirements are based on 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:

1. Initial assessment of the Covered Person's needs;
2. Family involvement and/or social support;
3. Psychological adjustment for the Covered Person;
4. General facts/overview on diabetes;
5. Nutrition including its impact on blood glucose levels;
6. Exercise and activity;
7. Medications;
8. Monitoring and use of the monitoring results;
9. Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
10. Use of community resources; and
11. Pregnancy and gestational diabetes, if applicable.

D. Diabetic Equipment and Supplies

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits, for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. If this Plan provides benefits for prescription drugs (other than coverage for insulin and oral agents only), Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, subject to the cost-sharing arrangements applicable to the prescription drug coverage.

1. Diabetic Equipment
   a. Blood glucose monitors;
   b. Insulin pumps;
   c. Insulin infusion devices; and
   d. Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

2. Diabetic Supplies
   a. Blood testing strips;
   b. Visual reading and urine test strips;
   c. Insulin and insulin analogs*;
   d. Injection aids;
   e. Insulin syringes;
   f. Lancets and lancet devices;
   g. Monitor supplies;
   h. Pharmacological agents for controlling blood sugar levels;* and
   i. Glucagon emergency kits.

   * If this Plan does not provide coverage for prescription drugs, insulin and oral agents are covered as provided under the "Insulin and Oral Agents" benefits.

E. Diagnostic Services

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

1. Routine Diagnostic Services, including routine radiology (consisting of x-rays, ultrasound, and nuclear medicine), routine medical procedures (consisting of ECG, EEG, and other diagnostic medical procedures approved by the Carrier), and allergy testing (consisting of percutaneous, intracutaneous and patch tests).

2. Non-Routine Diagnostic Services, including MRI/MRA, CT Scans, and PET Scans.

3. Diagnostic laboratory and pathology tests.

4. Genetic testing including those testing services provided to a Covered Person at risk by pedigree for a specific hereditary disease. The services must be for the purpose of diagnosis and where the results will be used to make a therapeutic decision.

F. Durable Medical Equipment

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Carrier, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Appropriate/Medically Necessary by the Carrier.

Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance. Therefore, Precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment that exceeds the amount shown in the *Schedule of Benefits*.

Durable Medical Equipment, as defined in the *Defined Terms* section, includes equipment that meets the following criteria:

1. It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered "durable". (For examples, see item d under "Durable Medical Equipment Exclusions" below.)
2. It customarily and primarily serves a medical purpose.
3. It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the Covered Person's illness, injury, or to improvement of a malformed body part.
4. It is appropriate for home use.

Durable Medical Equipment Exclusions: Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

1. Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.

2. Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.

3. Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, translift chairs and traction units.

4. Non-reusable supplies other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment. Items not covered include, but are not limited to, incontinence pads, lambs wool pads, ace bandages, antiembolism stockings, catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits.

5. Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to, ear plugs, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils, toileting systems, electronically-controlled heating and cooling units for pain relief, toilet seats, bathtub lifts, stairglides, and elevators.

6. Equipment with features of a medical nature which are not required by the Covered Person's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medical Appropriate/Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.

7. Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.

8. Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment.

9. Modifications to vehicles, dwellings and other structures. This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Covered Person's disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as a wheelchair.

Replacement and repair: The Carrier will provide benefits for the replacement of Durable Medical Equipment: (a) when there has been a change in the Covered Person's condition that requires the replacement, (b) if the equipment breaks because it is defective, or (c) it breaks because it exceeds its life expectancy, as determined by the manufacturer. If an item breaks and is under warranty, unless it is a rental item, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

The Carrier will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage. The Carrier will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

G. Emergency Care Services

Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are provided by the Carrier at the Preferred level of benefits, regardless of whether the patient is treated by a Preferred or Non-Preferred Provider. If Emergency Services are required, whether the Covered Person is located in or outside the Personal Choice Network service area, call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.

Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency. Outpatient follow-up care provided in a Medically Appropriate/Medically Necessary setting (in Emergency Room, other Outpatient Emergency Facility or physician's office) are also covered if received within 14 days of the initial Outpatient Emergency Care, as specified above.

Examples of an Emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severe Accidental Injury, and other acute medical conditions as determined by the Carrier. Should any dispute arise as to whether an Emergency existed or as to the duration of an Emergency, the determination by the Carrier shall be final.

H. Home Health Care

Benefits will be provided for the following services when performed by a licensed Home Health Care Agency:

1. Professional services of appropriately licensed and certified individuals;
2. Intermittent skilled nursing care;
3. Physical Therapy;
4. Speech Therapy;
5. Well mother/well baby care following release from an Inpatient maternity stay; and
6. Care within forty-eight (48) hours following release from an Inpatient Admission when the discharge occurs within forty-eight (48) hours following a mastectomy.

With respect to Item 5 above, Home Health Care services will be provided within forty-eight (48) hours if discharge occurs earlier than forty-eight (48) hours of a vaginal delivery or ninety-six (96) hours of a cesarean delivery. No Deductible, Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include Occupational Therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Carrier.

Home Health Care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Carrier as Medically Appropriate/Medically Necessary.

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.

With the exception of Home Health Care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be Homebound in order to be eligible to receive Home Health Care benefits. For purposes of this Home Health care benefit, the following definitions apply:

HOME – means a Covered Person's place of residence (e.g. private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility (SNF) at a custodial level of care.

HOMEBOUND – means there exists a normal inability to leave home due to severe restrictions on the Covered Person's mobility and when leaving the home: (a) it would involve a considerable and taxing effort by the Covered Person; and (b) the Covered Person is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

Home Health Care Exclusions: No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

1. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
2. Rental or purchase of Durable Medical Equipment;
3. 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;
4. Prescription drugs;
5. Services provided by a member of the Covered Person's Immediate Family;
6. Covered Person's transportation, including services provided by voluntary ambulance associations for which the Covered Person is not obligated to pay;
7. Emergency or non-Emergency Ambulance services;
8. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
9. Services provided to individuals (other than a Covered Person released from an Inpatient maternity stay), who are not essentially homebound for medical reasons; and
10. Visits by any Provider personnel solely for the purpose of assessing a Covered Person's condition and determining whether or not the Covered Person requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

I. Injectable Medications

Benefits will be provided for injectable medications required in the therapeutic treatment of an injury or illness, prescribed by a Professional Provider, and required for therapeutic use when determined to be Medically Appropriate/Medically Necessary by the Carrier. The administration of injectable medications is determined by the dosage regimen of the medication and the Physician prescribed treatment plan.

1. Biotech/Specialty Injectables

Refers to injectable medications included in the following list of Biotech/Specialty Injectables. Precertification is required for all Biotech/Specialty Injectables listed. This list is subject to change as new injectable medications come to market. The purchase of all Biotech/Specialty Injectables is subject to a Copayment if dispensed by a Preferred Provider or Coinsurance if dispensed by a Non-Preferred Provider. The Copayment and Coinsurance amounts are shown in the *Schedule of Benefits*. Copayment and Coinsurance amounts will apply: (a) to each thirty (30) day supply of medication dispensed for medications administered on a regularly scheduled basis; or (b) to each course/series of injections if administered on an intermittent basis. A ninety (90) day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness; in such a case, the Covered Person will be subject to three (3) Copayments, if applicable.

Biotech/Specialty Injectables:

Anticoagulant/Low Molecular Weight Heparin Agents:
Arixtra, Fragmin, Innohep, Lovenox,

Botulinum Toxin Agents
Botox, Myobloc

Endocrine/Metabolic Agents
Eligard, Faslodex, Lupron, Sandostatin, Trelstar, Vantas, Viadur, Zoladex

Growth Hormones
Genotropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, Saizen, Serostim, Tev-Tropin

Hematopoietic Agents
Aranesp, Epogen, Leukine, Neulasta, Neumega, Neupogen, Procrit
Hepatitis/Interferon Alfa Agents
Actimmune, Alferon, Infergen, Intron A, Pegasys, Peg Intron, Rebetron, Roferon-A
Hyaluronate Agents
Euflexxa, Hyalgan, Orthovisc, Supartz, Synvisc
Migraine Agents
Imitrex Injection
Multiple Sclerosis Agents/Interferon Beta Agents
Avonex, Betaseron, Copaxone, Rebif
Respiratory Agents
Synagis, Xolair
Immunological Modifiers
Amevive, Enbrel, Humira, Kineret, Raptiva
Miscellaneous
Apokyn, Forteo, Fuzeon, Somavert, Thyrogen

2. Standard Injectables

Refers to all other injectable medications including, but not limited to, allergy injections and extractions and injectable medications only administered in a Physician's office such as antibiotic and steroid injections.

J. Insulin and Oral Agents

Benefits will be provided for insulin and oral agents to control blood sugar as prescribed by a Physician and dispensed by a licensed pharmacy. Benefits are available for up to a thirty (30) day supply when dispensed from a retail pharmacy.

K. 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 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 Equipment supplier or in connection with Infusion Therapy as provided for in this plan.

L. Non-Surgical Dental Services

Benefits will be provided only for the initial treatment of Accidental Injury/trauma, (i.e. fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, including the first caps, crowns, bridges and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury. (See the exclusion of dental services in the *What Is Not Covered* section for more information on what dental services are not covered);

M. Orthotics

Benefits are provided for:

1. The initial purchase and fitting (per medical episode) of orthotic devices which are Medically Appropriate/Medically Necessary as determined by the Carrier, except foot orthotics unless the Covered Person requires foot orthotics as a result of diabetes.

2. The replacement of covered orthotics for Dependent children when required due to natural growth.

N. Podiatric Care

Benefits are provided for podiatric care including: capsular or surgical treatment of bunions; ingrown toenail surgery; and other non-routine Medically Necessary/Medically Appropriate foot care. In addition, for Covered Persons with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, benefits for routine foot care services are provided.

O. Private Duty Nursing Services

Benefits will be provided up to the number of hours specified in the *Schedule of Benefits* for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician and which are Medically Appropriate/medically Necessary as determined by the Carrier.

Benefits are not payable for:

1. 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;
2. Services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family; and
3. Services provided by a home health aide or a nurse's aide.

P. Prosthetic Devices

Expenses incurred for Prosthetic Devices (except dental prostheses) required as a result of illness or injury. Expenses for Prosthetic Devices are subject to medical review by the Carrier to determine eligibility and Medical Appropriateness/Medical Necessity.

Such expenses may include, but not be limited to:

1. The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
3. Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive surgery incident and subsequent to mastectomy. Coverage limitations on external breast prostheses are as follows:
   a. Post mastectomy, four (4) bras per Benefit Period are covered.
   b. The useful lifetime expectancy for silicone breast prostheses is two (2) years.
   c. The useful lifetime expectancy of fabric, foam or fiber-filled breast prostheses is six (6) months.
4. Benefits are provided for the following visual Prosthetics when Medically Appropriate/Medically Necessary and prescribed for one of the following conditions:
   a. Initial contact lenses prescribed for treatment of infantile glaucoma;
   b. Initial pinhole glasses prescribed for use after surgery for detached retina;
   c. Initial corneal or scleral lenses prescribed (1) in connection with the treatment of keratoconus; or (2) to reduce a corneal irregularity other than astigmatism;
   d. Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and

e. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of (1) Accidental Injury; (2) trauma, or (3) ocular surgery.

Benefits are not provided for:

a. Lenses which do not require a prescription;
b. Any lens customization such as, but not limited to tinting, oversize or progressive lenses, antireflective coatings, U-V lenses or coatings, scratch resistance coatings, mirror coatings, or polarization;
c. Deluxe frames; or
d. Eyeglass accessories, such as cases, cleaning solution and equipment.

The repair and replacement provisions do not apply to this item (4).

Benefits for replacement of a Prosthetic Device or its parts will be provided: (a) when there has been a significant change in the Covered Person's medical condition that requires the replacement, (b) if the prostheses breaks because it is defective, or (c) if the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer, or (d) for a Dependent child due to the normal growth process when Medically Appropriate/Medically Necessary.

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

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

Q. Specialist Office Visit

Benefits will be provided for Specialist Service medical care provided in the office by a Provider other than a Primary Care Provider. For the purpose of this benefit, "in the office" includes medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

R. Spinal Manipulation Services

Benefits shall be provided up to the limits specified in the *Schedule of Benefits* for spinal manipulations 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.

S. Therapy Services

Benefits shall be provided, subject to the Benefit Period Maximums specified in the *Schedule of Benefits*, for the following services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

1. Cardiac Rehabilitation Therapy

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

2. Chemotherapy

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-

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

3. Dialysis

The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

4. Infusion Therapy

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

5. Occupational Therapy

Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

6. Orthoptic/Pleoptic Therapy

Includes treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye surgery, or injury resulting in the lack of vision depth perception.

7. Pulmonary Rehabilitation Therapy

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

8. Physical Therapy

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part, including the treatment of functional loss following hand and/or foot surgery.

9. Radiation Therapy

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

10. Speech Therapy

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

What Is Not Covered

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

- Which are not Medically Appropriate/Medically Necessary as determined by the Carrier for the diagnosis or treatment of illness or injury;
- Which are Experimental/Investigative in nature;
- Which were Incurred prior to the Covered Person's effective date of coverage;
- Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the *General Information* section;
- For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;
- For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- 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 Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person 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 Covered Person claims the benefits or compensation;
- To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;
- 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 as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subscections entitled: (a) Therapy Services" (that identifies covered therapy services as provided by licensed therapists) and (b) "Ambulance Services" in the *Description of Benefits*;
- Rendered by a member of the Covered Person'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 under this Plan;

- For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. 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 and defined in the "Surgical Services" section in the *Description of Benefits*;

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

- For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;

- 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 the Carrier, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Carrier;

- For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet/certificate. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;

- For dental implants for any reason;

- For dentures, unless for the initial treatment of an Accidental Injury/trauma;

- For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;

- For injury as a result of chewing or biting (neither is considered an Accidental Injury);

- For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Appropriate/Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

- For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes;

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

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

- For treatment of obesity, except for surgical treatment of morbid obesity when the Carrier (a) determines the surgery is Medically Appropriate/Medically Necessary, and (b) the surgery is not a repeat, reversal or revision of any previous obesity surgery. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;]

- 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 weight reduction and premarital blood tests;

- For diagnostic screening examinations, except for mammograms and preventive care as provided in the "Primary and Preventive Care" section of the *Description of Benefits*;

- For routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment;

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

- For immunizations required for employment purposes, or for travel;

- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, Custodial Care in a Skilled Nursing Facility;

- For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided or allowed in the "Treatment for Alcohol or Drug Abuse and Dependency" or "Transplant Services" sections of the *Description of Benefits*;

- For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;

- As described in the "Durable Medical Equipment" and "Prosthetic Devices" sections in the *Description of Benefits*: for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the Covered Person's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

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

- For prescription drugs, except as may be provided by a prescription drug rider attached to this booklet/certificate. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;

- For contraceptive devices;

- For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient Admission;

- For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes 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 and defined in the "Medical Foods and Nutritional Formulas" section in the *Description of Benefits*;

- For Inpatient Private Duty Nursing services;

- For 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 Maintenance of chronic conditions;

- For charges Incurred for expenses in excess of Benefit Maximums as specified in the *Schedule of Benefits*;

- For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown on the *Schedule of Benefits*; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;

- For Cognitive Rehabilitation Therapy; (Cognitive Rehabilitation Therapy is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning and problem solving. It utilizes tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system);

- 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 hearing aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of hearing aids. Services and supplies related to these items are not covered;

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

- For cranial prostheses, including wigs intended to replace hair;

- For any Surgery performed for the reversal of a sterilization procedure;

- For any other service or treatment except as provided under this Plan.

A. Benefits To Which You Are Entitled

The liability of the Carrier is limited to the benefits specified in this booklet/certificate. The Carrier's determination of the benefit provisions applicable for the services rendered to you (a Covered Person) shall be conclusive.

B. Termination Of Your Coverage And Conversion Privilege Under This Plan

Termination of this Plan - Termination of the Group coverage (this Plan) automatically terminates all coverage for you (an Enrolled Employee) and your eligible Dependents. The privilege of conversion to a conversion contract shall be available to any Covered Person who has been continuously covered under the group contract for at least three (3) months (or covered for similar benefits under any group plan that this Plan replaced).

It is the responsibility of the Group to notify you and your eligible Dependents of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

If it is proven that you or your eligible Dependent obtained or attempted to obtain benefits or payment for benefits, through fraud or intentional misrepresentation, the Carrier, may, upon notice to you, terminate the coverage.

The privilege of conversion is available for you and your eligible Dependents except in the following circumstances:

1. The Group terminates this Plan in favor of group coverage by another organization; or
2. The Group terminates the Covered Person in anticipation of terminating this Plan in favor of group coverage by another organization.

Notice of Conversion - Written notice of termination and the privilege of conversion to a conversion contract shall be given within fifteen (15) days before or after the date of termination of this Plan, provided that if such notice is given more than fifteen (15) days but less than ninety (90) days after the date of termination of this Plan, the time allowed for the exercise of the privilege of conversion shall be extended for fifteen (15) days after the giving of such notice. Payment for coverage under the conversion contract must be made within thirty-one (31) days after the coverage under this Plan ends. Evidence of insurability is not required. Upon receipt of this payment, the conversion contract will be effective on the date of your termination under this Plan.

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

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

C. Termination Of Coverage At Termination Of Employment Or Membership In The Group

When a Covered Person ceases to be an eligible Employee or eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Plan are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person's termination under this Plan, the cost of such benefits will be the sole

responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under this Plan to be not more than sixty (60) days before the first day of the month in which the Group notified the Carrier of such termination.

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

Your protection under this Plan may be extended after the date you cease to be a Covered Person because of termination of employment or membership in the Group. It will be extended if, on that date, you are Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time you remain Totally Disabled from any such illness or injury, but not beyond twelve (12) months if you cease to be a Covered Person because your coverage under this Plan ends.

Coverage under this Plan will apply during an extension as if you were still a Covered Person, except any reinstatement of your Lifetime Maximum amount will not be allowed under the "Reinstatement" subsection in the *Schedule of Benefits*. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you though the Carrier by the Group. Continuation of coverage is subject to payment of the applicable premium.

E. Continuation Of Incapacitated Child

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you (an enrolled Employee) for over half of his support, you may apply to the Carrier to continue coverage of such child under this Plan upon such terms and conditions as the Carrier may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a dependent and mental or physical incapacity commenced prior to age nineteen (19).

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining nineteen (19) years of age. The disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over nineteen (19) years of age and joining the Carrier for the first time, the handicapped child must have been covered under the prior carrier and submit proof from the prior carrier that the child was covered as a handicapped person.

F. When You Terminate Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

This subsection, and the requirements of COBRA continuation, may or may not apply to the Group. You should contact your Employer to find out whether or not these continuation of coverage provisions apply.

For purposes of this subsection, a "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for benefits under this Plan as:
1. You, a covered Employee;
2. Your spouse; or
3. Your Dependent child.

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

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

<u>If An Employee Terminates Employment or Has a Reduction of Work Hours</u>: If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to eighteen (18) months, if:
1. Your termination of employment was not due to gross misconduct; and
2. You are not entitled to Medicare.

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

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within sixty (60) days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the eighteen (18) month continuation period described above for up to an extra eleven (11) months.

To elect the extra eleven (11) months of continuation, the plan administrator must be given written proof of Social Security's determination of the qualified beneficiary's disability before the earlier of:

1. The end of the eighteen (18) month continuation period; and
2. Sixty (60) days after the date the qualified beneficiary is determined to be disabled.

If, during the eleven (11) month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the plan administrator within thirty (30) days of such determination, and continuation will end, as explained in the "When Continuation Ends" paragraph of this subsection.

If an Employee Dies: If you (the covered Employee) die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months, subject to the "When Continuation Ends" paragraph of this subsection.

If an Employee's Marriage Ends: If your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months, subject to the "When Continuation Ends" paragraph of this subsection.

If an Employee Becomes Entitled to Medicare: If you become entitled to Medicare after terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months from the date the initial eighteen (18) month continuation period started, subject to the "When Continuation Ends" paragraph of this subsection.

If you become entitled to Medicare before terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to eighteen (18) months, but may be extended until thirty-six (36) months from the date you became entitled to Medicare, subject to the "When Continuation Ends" paragraph of this subsection.

If a Dependent Loses Eligibility: If your Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this booklet/certificate, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to thirty-six (36) months, subject to the "When Continued Ends" paragraph of this subsection.

Concurrent Continuations: If your Dependent who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your Dependent may elect to extend his or her eighteen (18) month continuation period to up to thirty-six (36) months, if during the eighteen (18) month continuation period your Dependent becomes eligible for thirty-six (36) months of group health benefits due to any of the reasons stated above.

The thirty-six (36) month continuation period starts on the date the initial eighteen (18) month continuation period started, and the two (2) continuation periods will run concurrently.

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify the plan administrator, in writing, of:

1. Your legal divorce or legal separation from your spouse;
2. Your Dependent child's loss of Dependent eligibility, as defined in this booklet/certificate; or
3. Social Security Administration's determination of disability

The notice must be given to the plan administrator within sixty (60) days of either of these events.

In addition, a disabled qualified beneficiary must notify the plan administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the plan administrator within thirty (30) days of such final determination.

The Employer's Responsibilities: Your employer must notify the plan administrator, in writing, of:

1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your death;
3. Your entitlement to Medicare; or
4. Commencement of Employer's bankruptcy proceedings.

The notice must be given to the plan administrator no later than thirty (30) days of any of these events.

The Plan Administrator's Responsibilities: The plan administrator must notify the qualified beneficiary, in writing, of:

1. His or her right to continue the group health benefits described in this booklet/certificate;
2. The monthly premium he or she must pay to continue such benefits; and
3. The times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within fourteen (14) days of:

1. The date the employer notifies the plan administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
2. The date the qualified beneficiary notifies the plan administrator, in writing, of your divorce or legal separation from your spouse, or your Dependent child's loss of eligibility.

The Employer's Liability: Your employer will be liable for the qualified beneficiary's continued group health benefits to the same extent as, and in the place of, the Carrier, if:

1. The plan administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above; or.
2. The employer fails to remit a qualified beneficiary's timely premium payment to the Plan on time, hereby causing the qualified beneficiary's group health benefit to end.

Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the plan administrator written notice that he or she elects to continue benefits under the coverage. This must be done within sixty (60) days of the date a qualified beneficiary receives notice of his or her continuation rights from the plan administrator as described above or sixty (60) days of the date the qualified beneficiary's group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

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

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional charge of two percent of the total premium charge may also be required by the employer.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra eleven (11) month continuation period.

If the qualified beneficiary fails to give the plan administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

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

When Continuation Ends: A qualified beneficiary's continued group health benefits under this Plan ends on the first to occur of the following:

1. With respect to continuation upon your termination of employment or reduction of work hours, the end of the eighteen (18) month period which starts on the date the group health benefits would otherwise end;
2. With respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional eleven (11) months of continuation, the earlier of:
   a. The end of the twenty-nine (29) month period which starts on the date the group health benefits would otherwise end; or
   b. The first day of the month which coincides with or next follows the date which is thirty (30) days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;
3. With respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered Dependent's eligibility, the end of the thirty-six (36) month period which starts on the date the group health benefits would otherwise end;
4. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
   a. After your termination of employment or reduction of work hours, the end of the thirty-six (36) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
   b. Before, your termination of employment or reduction of work hours where, during the eighteen (18) month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the eighteen (18) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than thirty-six (36) months from the date you become entitled to Medicare.
5. The date coverage under this Plan ends;
6 The end of the period for which the last premium payment is made;
7. The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
8. The date he or she becomes entitled to Medicare.

THE CARRIER'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BOOKLET/CERTIFICATE.

THE CARRIER IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

G. Release Of Information

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

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

The Carrier shall provide to the Group at the Group's request certain information regarding claims and charges submitted to the Carrier. The parties understand that any information provided to the Group will be adjusted by the Carrier to prevent the disclosure of any information that is protected by applicable state or federal laws of any Employee or other Covered Person treated by said Providers. The Group shall reimburse the Carrier for the actual costs of preparing and providing said information.

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

H. 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 Identification Card.

I. Limitation Of Actions

No legal action may be taken to recover benefits prior to sixty (60) days after notice of claim has been given as specified above, and no such action may be taken later than three (3) years after the date Covered Services are rendered.

J. Claim Forms

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

K. Timely Filing

The Carrier will not be liable under this Plan unless proper notice is furnished to the Carrier that Covered Services have been rendered to a Covered Person. Written notice must be given within twenty (20) days after completion of the Covered Services. The notice must include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Carrier within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Carrier be required to accept notice more than two (2) years after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by Preferred Providers.

L. Covered Person/Provider Relationship

1. The choice of a Provider is solely the Covered Person’s choice.
2. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by persons covered under this Plan. The Carrier is not liable for any act or omission of any Provider. The Carrier has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

M. Subrogation

In the event any service is provided or any payment is made to a Covered Person, the Carrier shall be subrogated and succeed to the Covered Person's rights of recovery against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in your name. The Covered Person shall execute and deliver such instruments and take such other reasonable action as the Carrier may require to secure such rights. The Covered Person may do nothing to prejudice the rights given the Carrier without the Carrier's consent.

The Covered Person shall pay the Carrier all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Plan and as permitted by law.

The Carrier's right of subrogation shall be unenforceable when prohibited by law.

N. Coordination Of Benefits

This Plan's Coordination of Benefits (COB) provision is designed to conserve funds associated with health care. The following provisions do not apply to prescription drug coverage when provided through endorsement to this Plan.

1. Definitions

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

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

a. Individual, group, (except hospital indemnity plans of less than $200), 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.

2. Determination of Benefits

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

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

When an Employee has group health care coverage under this Plan 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 the parent 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 the 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 an Employee who is neither laid off nor retired (or as that Employee's Dependent) is primary to a Plan which covers that patient as a laid off or retired Employee (or as that Employee's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

d. If none of the above rules apply, the Plan which covered the Employee longer shall be primary.

3. Effect on Benefits

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

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

Certain facts are needed to apply COB. The Carrier has the right to decide which facts are needed. The Carrier may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Carrier deems necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Carrier such information as may be necessary to implement this provision. The Carrier, 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 Plan shall be affected by the benefits that would be payable under any and all other Plans only to the extent that the Carrier is furnished with information relative to such other Plans.

Right of Recovery

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, the Carrier 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 Plan and, to the extent of such payments, the Carrier shall be fully discharged from liability under this Plan.

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

1. The person the Carrier has paid or for whom they have paid;
2. Insurance companies; or
3. Any other organizations.

You, on your own behalf and on behalf of your Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to the Carrier.

O. Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for Covered Services under this coverage (e.g., obtaining Precertification, use of Preferred, Participating or Member Providers), or to the administration of this benefit program by the Carrier, the Carrier may on a selective basis, waive certain procedural requirements of this coverage. 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 Carrier 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 Carrier nor the Providers in the Carrier's PPO network shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances as recognized in the community, and by the Carrier and appropriate regulatory authority, are extraordinary circumstances not within the control of the Carrier, 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.

A. Utilization Review Process

A basic condition of IBC's, and its subsidiary QCC Insurance Company's ("the Carrier") benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Appropriate/Medically Necessary. To assist the Carrier in making coverage determinations for requested health care services, the Carrier uses established IBC Medical Policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

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

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Carrier follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

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

The Carrier's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to the Carrier's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Carrier does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. Clinical Criteria, Guidelines And Resources

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

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Carrier in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff evaluating the Medical Appropriateness/Medical Necessity of coverage based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Carrier's plan determinations for similar medical issues and requests, and reduces practice variation among the Carrier's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following:

- Some elective surgeries-settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery).
- Inpatient hospitalizations
- Inpatient Rehabilitation
- Home Health
- Durable Medical Equipment
- Skilled Nursing Facility

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

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

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

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

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

C. Delegation Of Utilization Review Activities And Criteria

The Carrier delegates its utilization review process to the Carrier's affiliate, Independence Healthcare Management ("IHM"). IHM is a state licensed utilization review entity and is responsible for the Carrier's utilization review process. In certain instances, the Carrier has delegated certain utilization review activities, including Precertification review, concurrent review, and case management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, Neonates/premature infants) or type of benefit or service (such as mental health/substance abuse or radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Carrier's approval.

Utilization Review and Criteria for Mental Health/Substance Abuse Services

Utilization Review activities for mental health/substance abuse services have been delegated by IBC (and QCC) to a behavioral health management company, which administers the mental health and substance abuse benefits for the majority of the Carrier's Covered Persons.

D. Precertification Review

When required, Precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Covered Person's benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. For groups located in the Personal Choice Network service area, Precertification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a Personal Choice Network Provider. For Covered Person's located outside the Carrier's Personal Choice Network who are accessing BlueCard Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Precertification review. Where Precertification review is required, the Carrier's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for Medical Appropriateness of the requested procedure setting (e.g., Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Appropriateness/Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing provider. Precertification review is not required for Emergency services and is not performed where an agreement with the Carrier's local Preferred or Participating Provider does not require such review. The following are general examples of current Precertification review requirements under benefit plans; however, these requirements vary by benefit plan and state and are subject to change.

- Hysterectomy
- Nasal surgery procedures
- Bariatric surgery
- Potentially cosmetic or experimental/investigative procedures

The following information provides more specific information of this benefit plan's Precertification requirements.

1. Inpatient Pre-Admission Review

Preferred Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Carrier as to the Medical Appropriateness/Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this *Managed Care* section. A Preferred Hospital, Skilled Nursing Facility, or other Facility Provider in the Personal Choice Network will verify the Precertification at or before the time of admission. However, the Covered Person, not the Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard PPO Program. The Carrier will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if Precertification is required and is not obtained in advance. For Covered Person's who reside in the Carrier's local Personal Choice Network service area, the Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for admissions to Hospitals, Skilled Nursing Facilities or other Facility Providers in the Personal Choice Network which fail to conform to the pre-admission certification requirements unless: (a) the Provider provides prior written notice that the admission will not be paid by the Carrier; and (b) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Facility Provider admission.

Non-Preferred Inpatient Admissions

For a Non-Preferred Inpatient Admission and an Inpatient Admission to a BlueCard PPO Provider, the Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Precertification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact the Carrier prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Carrier will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Non-Preferred level shown in the *Schedule of Benefits* if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet/certificate.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown in the *Schedule of Benefits*, will be deemed not to be Covered Services under this coverage. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

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

c. If Precertification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. Emergency Admission Review

a. Preferred Admissions

   It is the responsibility of the Preferred Provider to notify the Carrier of the In-Network Emergency admission.

b. Non-Preferred and BlueCard Provider Admissions

   1. Covered Persons are responsible for notifying the Carrier of a Non-Preferred or BlueCard Provider Emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Carrier.

   2. Failure to initiate Emergency admission review will result in a reduction in Covered Expense for Non-Preferred services. Such penalty, as shown in the *Schedule of Benefits*, will be the sole responsibility of, and payable by, the Covered Person.

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

3. Concurrent And Retrospective Review

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent

review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent Review is generally not performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with the Facility does not require such review.

Retrospective/Post Service review:

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

In addition to these standard utilization reviews, the Carrier also may determine coverage of certain procedures and other benefits available to Covered Persons through prenotification as required by the Covered Person's benefit plan, and discharge planning.

Pre-notification. Pre-notification is advance notification to the Carrier of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge Planning. Discharge Planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Carrier's authorization of covered post-Hospital services and identifying and referring Covered Persons to disease management or case management benefits.

Selective Medical Review. In addition to the foregoing requirements, the Carrier reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("Selective Medical Review") that are otherwise not subject to review as described above. In addition, the Carrier reserves the right to waive medical review for certain Covered Services for certain Providers, if the Carrier determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services. Coverage penalties are not applied to Covered Persons where required Selective Medical Review is not obtained by the Provider.

E. Other Precertification Requirements

Precertification is required by the Carrier in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Outpatient treatment (including Partial Hospitalization services) of Alcohol and Drug Abuse, Mental Health/Psychiatric Care and Serious Mental Illness. A complete list of Precertification requirements is shown in the "Services Requiring Precertification" subsection of this *Managed Care* section. When a Covered Person plans to receive any of these listed procedures, the Carrier will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed in the "Services Requiring Precertification" subsection of this *Managed Care* section, that are performed during an Emergency, as determined by the Carrier, do not require Precertification. However, the Carrier should be notified within two (2) business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Carrier.

1. Preferred Care

Preferred Providers in the Personal Choice Network must contact the Carrier to initiate Precertification. The Carrier will verify the results of the Precertification with the Covered Person and with the Preferred Provider. If the Preferred Provider is a BlueCard PPO Provider, however, the Covered Person must initiate Precertification.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the "Services Requiring Precertification" subsection of this *Managed Care* section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, subject to a Penalty.

For Preferred Providers in the Personal Choice Network, the Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for this financial Penalty for the Preferred Provider's failure to comply with the Precertification requirements or determination, unless a Covered Person elects to receive the treatment after review and written notification that the procedure is not covered as Medically Appropriate/Medically Necessary. In which case benefits will not be provided and the Covered Person will be financially liable for non-covered charges.

2. Non-Preferred Care

For Non-Preferred Care and care provided by BlueCard Providers, the Covered Person is responsible to have the Provider performing the service contact the Carrier to initiate Precertification. The Carrier will verify the results of the Precertification with the Covered Person and the Provider.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the "Services Requiring Precertification" subsection of this *Managed Care* section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty, as shown in the *Schedule of Benefits*. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

F. Services Requiring Precertification

The following services must be Precertified whether Preferred (In-Network) or Non-Preferred (Out of Network), unless otherwise noted.

1. All Inpatient Admissions
   a. Acute Rehabilitation
   b. Alcohol and Drug Abuse
   c. Inpatient Hospice
   d. Maternity (notification only)
   e. Mental Health/Psychiatric Care, Serious Mental Illness
   f. Skilled Nursing Facility
   g. Surgical/Non-Surgical (including Transplants)

2. Outpatient Services
   a. Alcohol and Drug Abuse (including Partial Hospitalization services)
   b. Ambulance Services – non-Emergency
   c. Birth Center (notification only)
   d. Day Rehabilitation Program
   e. Durable Medical Equipment (items over $500 billed amount, including repairs and replacements, and all rentals). This Precertification requirement does not apply to oxygen, diabetic supplies and unit dose medication for nebulizers.
   f. Home Health Care
   g. Mental Health/Psychiatric Care, Serious Mental Illness (including Partial Hospitalization services)
   h. Non-Surgical Dental Services
   i. Comprehensive Pain Management Programs (including epidural injections)
   j. Private Duty Nursing
   k. Orthotics and Prosthetics (items over $500 billed amount, including repairs and replacements). This Precertification requirement does not apply to ostomy supplies.
   l. Sleep Studies

3. Diagnostic Services
   a. CT/CTA Scans
   b. MRI/MRA
   c. Nuclear Cardiology Imaging
   d. PET Scans

4. Surgical Procedures (regardless of place of service)
   a. Cataract Surgery
   b. Hysterectomy
   c. Nasal Surgery for submucous resection and septoplasty
   d. Obesity Surgery
   e. Transplants (except cornea)
   f. Uvulopalatopharyngoplasty (including laser-assisted)

5. Surgical/Reconstructive Procedures
   a. Abdominoplasty
   b. Augmentation mammoplasty
   c. Blepharoplasty
   d. Chemical Peels and Dermabrasion
   e. Excision of redundant skin
   f. Keloid Removal
   g. Lipectomy/Liposuction
   h. Mastopexy
   i. Orthognathic surgery procedures
   j. Otoplasty
   k. Panniculectomy
   l. Reduction Mammoplasty
   m. Removal or Reinsertion of breast implants
   n. Rhinoplasty
   o. Scar Revision
   p. Subcutaneous Mastectomy for Gynecomastia
   q. Surgery for varicose veins

6. Infusion Therapy

   1. Infusion Therapy in a home setting
   2. Drugs listed below that are given by Infusion Therapy when such Infusion Therapy is provided in an Outpatient Facility or in a Professional Provider's office.

      *Aldurazyme, Aredia, Avastin, Boniva, Ceredase, Cerezyme, Elaprase, Erbitux, Fabrazyme, Genasense, Herceptin, IVIG, Myozyme, Orencia, Remicade, Respigam, Tysabri

   *Infusion drugs that are newly approved by the FDA during the effective term of the Group Contract are considered new and emerging technology and will be subject to Precertification, pending notification by the Carrier. No penalty associated with failure to obtain Precertification approval for any drug not found on the list above, will be applicable to a Covered Person until such time as the Group Contract and booklet/certificate form are amended accordingly.

THE ABOVE LIST OF PRECERTIFICATION REQUIREMENTS IS SUBJECT TO CHANGE ANNUALLY. PRIOR NOTIFICATION WILL BE PROVIDED.

7. Biotech/Specialty Injectable Drugs (see list under "Biotech/Specialty Injectables" in *Description of Benefits*)

THIS LIST OF BIOTECH/SPECIALTY MEDICATION PRECERTIFICATION REQUIREMENTS IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. PRIOR NOTIFICATION WILL BE PROVIDED

In addition to the Precertification requirements listed above, the Covered Person should contact the Carrier for certain categories of treatment (listed below) so that the Covered Person will know prior to receiving treatment whether it is a Covered Service. This applies to Preferred Providers in the Preferred Provider Organization network and to Covered Persons (and their Providers) who elect to receive treatment provided by either BlueCard Providers or Non-Preferred (Out-of-Network) Providers. Those categories of treatment (in any setting) include:

1. Any surgical procedure that may be considered potentially cosmetic;

2. Any procedure, treatment, drug or device that represents "emerging technology", and

3. Services that might be considered Experimental/Investigative.

The Covered Person's Provider should be able to assist in determining whether a proposed treatment falls into one (1) of these three (3) categories. Also, the Carrier encourages the Covered Person's Provider to place the call for the Covered Person.

For more information, please see the ***Notices*** placed in the front pages of this booklet/certificate that pertain to Experimental/Investigative services, Cosmetic services, Medically Appropriate/Medically Necessary services and Emerging Technology.

G. Disease Management And Decision Support Programs

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

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

The Carrier will utilize medical information such as claims data to operate the Disease Management or Decision Support program, e.g. to identify Covered Persons with chronic disease, to predict which Covered Persons would most likely benefit from these services, and to communicate results to Covered Person's treating Physician(s). The Carrier will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Covered Person in Disease Management or Decision Support programs is voluntary. A Covered Person may continue in the Disease Management or Decision Support program until any of the following occurs: 1. the Covered Person notifies the Carrier that he/she declines participation; or 2. the Carrier determines that the program, or aspects of the program, will not continue.

H. Out-Of-Area Care For Dependent Students

If an unmarried Dependent child is a full-time student in an Accredited Educational Institution located outside the area served by the Personal Choice Network, the student may be eligible to receive Non-Preferred care at the Preferred level of benefits. Charges for treatment will be paid at the Preferred level of benefits when the Dependent student receives care from Providers as described in the "BlueCard PPO Program" subsection of the *Your Personal Choice Network Plan* section. However, treatment provided by an educational facility's infirmary for Urgent Care, for example, may also be paid at the Preferred level of benefits, but the Carrier should be notified within forty-eight (48) hours of treatment to insure Covered Services are treated as Preferred Covered Services. Nothing in this provision will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under this Plan.

For purposes of this section only, the term "Member" replaces the term "Covered Person."

Member Complaint Process

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

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Carrier 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 Carrier maintains procedures for the resolution of Member Appeals. Member Appeals may be filed within one hundred eighty (180) days of the receipt of a decision from the Carrier stating an adverse benefit determination. An Appeal occurs when the Member or, after obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Carrier by following the procedures described here. (In order to authorize someone else to be the Member's representative for the Appeal, the Member must complete a valid authorization form. The Member must contact the Carrier as directed below to obtain a "Member/Enrollee Authorization to Appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an Appeal by calling or writing to the Carrier, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820.

Toll Free Phone: 1-888-671-5276
Toll Free Fax: 1-888-671-5274 or
Phila. Fax: 215-988-6558

Types of Member Appeals and Applicable Timeframes. Following are the two types of Member Appeals and the issues they address:

- Medical Necessity Appeal – An Appeal by or on behalf of a Member that focuses on issues of Medical Appropriateness/Medical Necessity and requests the Carrier to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include Appeals of adverse benefit determinations based on the exclusions for Experimental/Investigative or cosmetic services.

- Administrative Appeal – An Appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Carrier 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 Appropriateness/Medical Necessity, 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 Appeal timeframes apply to both pre-service Appeals and post-service Appeals that concern claims for non-urgent care.

> Pre-service Appeal - An Appeal for benefits that, under the terms of the Plan, must be Precertified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available. A maximum of fifteen (15) days is available for each of the two (2) levels of internal review available for a standard Pre-service Appeal.
>
> 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.) A maximum of thirty (30) days is available for each of the two (2) levels of internal review available for a standard Post-service Appeal.

Expedited Appeal timeframes apply to pre-service requests for Urgent Care.

> Expedited/Urgent appeal – An Appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Carrier 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. A maximum of seventy-two (72) hours is available for internal review of an Expedited Appeal.

Information for the Appeal Review including Matched Specialist's Report. At all Appeal levels the Member may submit to the Carrier additional information pertaining to his case. The Member may specify the remedy or action being sought. Upon request at any time during the Appeal process, the Carrier will provide the Member or his authorized representative access to, and copies of all relevant documents and records, including information reviewed by the decision maker(s) on the Appeal.

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 Appeals Committee described below will be comprised of employees of the Carrier who have been designated to act as decision maker(s) on the Appeal. The Committee decision maker(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.

Right to Pursue Civil Action. If the Member is enrolled in a group health plan that is subject to the requirements of Employee Retirement Income Security Act of 1974 (ERISA), he has the right to bring a civil action under Section 502(a) of the Act after completing the Member Appeal processes described here.

Changes in Member Appeals Processes. Please note that the Member Appeal processes described here may change due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve the Member Appeals processes, or to reflect decisions of the Group regarding the administration of Member Appeal processes for this Plan.

Internal Standard And Expedited Appeals

There are two levels of internal standard Appeal and one level of internal expedited Appeal.

Level One Standard Appeal

An acknowledgement letter and description of the Appeal process is mailed within five (5) business days of receipt of a Member Appeal. The initial request for an Appeal will be evaluated and the decision completed within the following timeframes for a standard Appeal on an Administrative or Medical Necessity Appeal issue:

Standard Pre-service Appeal – within fifteen (15) days of receipt of the Appeal request
Standard Post-service Appeal – within thirty (30) days of receipt of the Appeal request

The Member will be sent written notice of the first level decision within the timeframe stated above that applies to the Appeal. If the Member's 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 the Member that relevant information is available, and describe how he can Appeal to the next level. The first level Appeal decision for a Standard Appeal is final unless the Member exercises his right to appeal the decision as described below.

Level Two Standard Appeal

If the Member is not satisfied with the first level decision, he may request a second level Appeal within sixty (60) days. The Appeal will be evaluated and the decision completed within the following timeframes for the second level review of a Standard Appeal on an Administrative or Medical Necessity Appeal issue:

Standard Pre-service Appeal – within fifteen (15) days of receipt of the Appeal request
Standard Post-service Appeal – within thirty (30) days of receipt of the Appeal request

The Member or his authorized representative has the right to present the Member's Appeal to the Second Level Appeal Committee in person or via conference call. The Second Level Appeal Committee meeting is a forum where Members each have an equal amount of time to present their issues in an informal setting that is not open to the public. Two (2) other people may accompany the Member, unless the Member receives prior approval from the Carrier for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not audiotape, videotape, or transcribe the committee proceedings. The Carrier will contact the Member to schedule the Committee meeting for his Standard Appeal. The Appeal review may also occur based on the Appeal record without the Member's participation if he does not want to participate or repeated attempts to schedule the Member's participation fail.

Written notice of the second level decision will be sent within the timeframes stated above. If the Member's 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, and tell the Member what relevant information is available.

The second level decision is final with respect to the Member's right to review of an Administrative Appeal through the Carrier's Member Appeal process. Additional Appeal rights for review of Medical Necessity Appeals are described below under "External Standard and Expedited Medical Necessity Appeals."

Expedited Appeals

If a Member's case involves a serious medical condition which he believes may jeopardize his life, health, ability to regain maximum function, or would subject him to severe pain that cannot be adequately managed while awaiting a Standard Appeal decision, the Member may ask to have his case reviewed in a quicker manner, as an Expedited Appeal. An Expedited Appeal consists of only one level of internal review for which the evaluation and decision must be completed within the following timeframe:

Expedited Pre-service Appeals - within seventy-two (72) hours of receipt of the Appeal request.

To request an Expedited Appeal by the Carrier, the Member should call Member Services at the toll free telephone number listed on the back of his Identification Card, or call, or fax the Member Appeals Department at the phone numbers listed above. Information related to the Member's Appeal will be requested and he will be promptly informed

whether it qualifies for review as an Expedited Appeal or must instead be processed as a Standard Appeal. The Committee will also 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.

A Member has the right to present his Appeal to the Committee in person or via conference call. The Expedited Appeal Committee meeting is a forum where Members each have an equal amount of time to present their issues in an informal setting that is not open to the public. Two (2) other people may accompany the Member unless he receives prior approval for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member's representative. Members may not audiotape, videotape, or transcribe the committee proceedings. While efforts will be made to accommodate the participants requested by the Member or his authorized representative, Expedited Appeals must adhere to the established time limits.

The Expedited Appeal review will be completed promptly based on the Member's health condition, but no later than seventy-two (72) hours after receipt of his Expedited Appeal by the Carrier. The Member will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. The Expedited Appeal decision is then final with respect to a Member's right to review of an Administrative Appeal through the Carrier's Member Appeal process. Additional Appeal rights for review of Medical Necessity Appeals are described below under "External Standard and Expedited Medical Necessity Appeals."

External Standard And Expedited Medical Necessity Appeals

If the Member is not satisfied with the decision of the internal Second Level Medical Necessity Appeal Committee or Expedited Medical Necessity Appeal Committee, he may file an external appeal—standard or Expedited—as described below. Both types of external Medical Necessity Appeals are submitted to Independent Review Organizations (IROs). When the Carrier, assigns an IRO to an external Medical Necessity Appeal, the decision is rendered at no cost to the Member involved in the external Medical Necessity Appeal. If the IRO decides that the care or services requested in the external Medical Necessity are Covered Services that are Medically Necessary, then the IRO notifies the Member or his authorized representative in writing that the prior Appeal decision is overturned and the Carrier follows-up by arranging for service approval or claim payment as appropriate.

External Standard Medical Necessity Appeal:

The Member or his authorized representative may request an external Medical Necessity Appeal review by an IRO by calling or writing to the Carrier within one hundred and eighty (180) calendar days of receipt of the internal Appeal decision letter. The Member or his authorized representative may also request an external Appeal review at any time during the internal Appeals process if the Carrier exceeds the time limit for making a decision. To request an external Medical Necessity Appeal review by an IRO, call or write to the Member Appeals Department at the phone number or address listed above under the section entitled "Member Appeal Process – Filing an Appeal." The Carrier will acknowledge receipt of the Member's external standard Grievance Appeal in writing. (If the Carrier overturns the prior decision at any time while his external Appeal is pending due to receipt of additional information, the IRO is notified and, with the Member's permission, the external review is ended.)

The Member and his authorized representative are not required to pay any of the costs associated with the external review.

The Member is sent written confirmation of receipt of his external Medical Necessity review request from the Carrier within five (5) business days of receipt of the request. This confirmation includes the name and contact information for the Carrier staff person assigned to facilitate the processing of the Member's Appeal and information on the IRO assignment. Information on the IRO assignment identifies the assigned IRO by name and states the board certification and/or specialty of the physician or psychologist that the IRO appoints to review the Member's Appeal.

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

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Carrier, with the Member, or his authorized representative. The Carrier's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Carrier assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal Appeal process, nor a subordinate of that person. If the Member feels that a conflict exists, he should call or write the contact person listed on the acknowledgement letter from the Carrier no later than two (2) business days from receipt of the acknowledgment letter from the Carrier.

Within fifteen (15) calendar days of receipt of the Member's request, the Carrier sends the Member, his authorized representative, and the IRO a letter listing all documents forwarded to the IRO. These documents include copies of all information submitted for the internal Appeal process, as well as any additional information that the Member, his authorized representative, or the Carrier may submit. If the Member wishes to submit additional information for consideration by the IRO, he should do so within ten (10) calendar days of the Member's request for an external Appeal.

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

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

The external decision is binding on the Carrier.

External Expedited Medical Necessity Appeal

The Member or his authorized representative may request an external expedited third level Medical Necessity review if the Member's case involves a serious medical condition which the Member believes may jeopardize his life, health, ability to regain maximum function, or would subject him to severe pain that cannot be adequately managed while awaiting a standard decision. This request can be made after the Member has completed the internal process or if the Carrier exceeds the time limit for making a decision. To request an external expedited Medical Necessity review by an IRO, the Member should call or write to the Member Appeals Department at the phone number or address listed above under the section entitled "Member Appeal Process – Filing an Appeal." (If the Carrier overturns the prior decision at any time while the Member's external Appeal is pending due to receipt of additional information, the IRO is notified, and with the Member's permission, the external review is ended.)

The Member and his authorized representative are not required to pay any of the costs associated with the external review.

Within twenty-four (24) hours of receipt of the Member's request for an expedited Appeal, the Carrier confirms his request is for an external expedited Medical Necessity Appeal and faxes his request to the assigned IRO. During this time, the Carrier also forwards to the IRO, by secure electronic transmission or overnight delivery, all information submitted in the internal Appeal process and any additional information that the Member, his authorized representative, or the Carrier wishes to submit to the IRO.

Whenever possible, the IRO assigned to the external expedited Appeal is a different organization than the one that supplied the matched specialist for the internal Appeal process. The Physician or psychologist appointed by the IRO to review the Member's external Appeal has not been previously involved in any aspect of decision-making on the Appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Carrier, with the Member, or with his authorized representative. The Carrier's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Carrier assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal Appeal process, nor a subordinate of that person. If the Member feels that a conflict exists, the Member should immediately contact the person listed on the acknowledgement letter from the Carrier.

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

The IRO makes a decision and simultaneously notifies the Member or his authorized representative and the Carrier in writing within forty-eight (48) hours of receipt of all relevant documentation. The decision letter identifies the assigned IRO by name and states the board certification and/or specialty of the Physician or psychologist that the IRO appoints to review the external Appeal.

The time period for issuing the final decision on the expedited Medical Necessity Appeal can be extended for five (5) calendar days for good cause when such a delay is acceptable to the Member or his authorized representative.

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

The external decision is binding on the Carrier.