

Comprehensive Major Medical
Health Benefits Program

Self-Referred Benefits



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

QCC Insurance Company
(Hereafter called "The Carrier")

GROUP HEALTH BENEFITS BOOKLET/CERTIFICATE

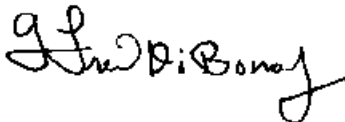
The Carrier certifies that You are entitled to the benefits described in this Booklet/Certificate as subject to the eligibility and effective date requirements of the Group Contract.

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 Contract provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

ATTEST:

BY



G. Fred DiBona, Jr., Esq.
Chairman, President and
Chief Executive Officer

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Introduction

This booklet/certificate has been prepared so that you may become acquainted with the Comprehensive Major Medical Program offered by your employer. Coverage under your employer's plan is available to active employees who are eligible for the Coverage and enrolled in it. The Comprehensive Major Medical Program described in this booklet/certificate is subject to the terms and conditions of the group contract issued by QCC Insurance Company.

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 Notice" below:

Important Notice

Regarding Experimental or Investigative Treatment:

The Carrier does not cover treatment it determines to be Experimental or 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 or Investigative treatment. If a Covered Person receives Experimental or Investigative treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her physician may contact the Carrier to determine whether a treatment is considered Experimental or Investigative. The term "Experimental or Investigative" is defined in the Definitions section of this booklet/certificate.

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 our decision and will not bill the Covered Person for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary without that person's consent. 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 terms "Medically Appropriate" and "Medically Necessary" are defined in the Definitions section of this booklet/certificate.

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 may contact the Carrier to determine whether treatment is for Cosmetic purposes.

The exclusion for services and operations for cosmetic purposes is detailed in the Exclusions section of this booklet/certificate.

Your Comprehensive Major Medical Benefits Plan

You can get the maximum benefits from your Comprehensive Major Medical coverage by using Member/Contracting Providers and Participating Professional Providers. The benefits of using these Providers include:

Lower coinsurance payments. When you use a participating doctor, the coinsurance you pay will be a percentage of our contracted rate. This rate is lower than what the doctor normally charges. If you use a Member Hospital, the Plan-wide discount will be subtracted from the total charges before your coinsurance percentage is calculated.

You don't have to shop around for the lowest provider costs; we have done it for you. This means less money out of your pocket.

No Balance Billing. Participating doctors and Member Hospitals agree to accept the amount we pay, plus your coinsurance. If you go to a Non-Participating doctor or Non-Member Hospital, we will pay the applicable percentage of the Reasonable and Customary fee. You pay the balance of this amount; plus, if the doctor charges rates higher than those normally charged in the geographic area, you will pay the extra amount.

In some categories, some providers (other than Participating doctors and Member Hospitals) have retained the right to balance bill. While some providers in these categories will accept our payment, plus your coinsurance, this is not always the case. When calling a specific provider in these categories, ask if they will balance bill and, if so, how much.

No Claim Forms. When using a network provider, you never have to fill out a claim form.

Pre-Certification. A list of services that require pre-certification is shown in the Managed Care section of this booklet/certificate. If you are ever unsure over whether to pre-certify, **call us.** Just use the toll-free number shown on your identification card.

Self-Referred Benefits

The benefits described in this booklet/certificate are the benefits provided when you choose to receive health care services without obtaining a referral from your Primary Care Physician (called "Self-Referred Care"). When you choose Self-Referred care, the level of benefits are, in most cases, subject to an annual deductible, coinsurance payments and lifetime and benefit period maximums, so you will be responsible for a greater share of out-of-pocket expenses. You also may be required to file a claim form.

Some of the services you receive must be pre-certified before you receive them, to determine whether they are Medically Appropriate/Medically Necessary. Failure to pre-certify Self-Referred services, when required, may result in a reduction of benefits. You will be financially liable for penalties assessed for failure to pre-certify Self-Referred benefits.

Schedule Of Benefits

Subject to the Exclusions, conditions and limitations of the Carrier as set forth in this booklet/certificate, a Covered Person is entitled to benefits for the Covered Services described in this Benefits section during a Benefit Period, subject to the Deductible, if any, and in the amounts as specified in this Schedule of Benefits. The Coinsurance percentage shown below is not always calculated on actual charges. For an explanation on how your coinsurance is calculated, see the "Covered Expense" definition in the "Definitions" section of the booklet/certificate.

Benefit Period	Calendar Year
Individual Deductible	\$500 per Benefit Period per Covered Person.
Family Deductible	3 times the Individual Deductible amount must be incurred by Covered Persons in a Family in each Benefit Period.
Coinsurance	Carrier pays 70% Alcohol and Drug Abuse Services, in the first instance or course of treatment, no deductible or co-payment shall be less favorable than those applied to similar classes or categories of treatment for physical illness.
Individual Out-Of-Pocket Limit	\$3,000
Family Out-Of-Pocket Limit	2 times the individual Out-of-Pocket amount must be incurred by Covered Persons in a Family in each Benefit Period.
Lifetime Maximum	\$1,000,000 per lifetime per Covered Person.

Schedule Of Covered Services

Covered Services	Carrier Pays
<p>Hospital Services Inpatient (120 days for Room and Board and Ancillary Services per Benefit Period.)</p> <p>Outpatient</p>	<p>70%</p> <p>70%</p>
<p>Emergency Accident/Emergency Medical Services within 2 days of Emergency. Follow-up emergency room care within 14 days of initial treatment.</p>	<p>100% after applicable “Referred” co-payment. Refer to your member handbook/co-payment schedule for co-payment amount.</p>
<p>Surgical Services If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier shall pay the Provider’s charge for the highest paying procedure and no allowance for additional procedures except where the Carrier deems that an additional allowance is warranted.</p>	<p>70%</p>
<p>Assistant Surgeon If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier shall pay the Provider’s charge for the highest paying procedure and no allowance for additional procedures except where the Carrier deems that an additional allowance is warranted.</p>	<p>70%</p>
<p>Anesthesia Services administered by a nurse anesthetist not employed by a Professional Provider are paid at 50% of the Provider’s Reasonable and Customary charge.</p>	<p>70%</p>
<p>Second Surgical Opinion (Voluntary)</p>	<p>70%</p>
<p>Medical Care Inpatient Concurrent Care Consultations Consultations are limited to 1 per consultant per confinement Outpatient, includes office and home visits</p>	<p>70%</p> <p>70%</p> <p>70%</p> <p>70%</p>
<p>Diagnostic Services—Outpatient</p>	<p>70%</p>

Covered Services	Carrier Pays
Spinal Manipulations \$1,000 Benefit Period Maximum	70%
Therapy—Outpatient Chemotherapy, Dialysis, Radiation \$5,000 Aggregate Maximum per Benefit Period for: Physical, Cardiac, Respiratory, Occupational, and Speech Therapy	70%
Maternity Obstetrical/Maternity Elective Abortions Newborn Care	70%
Psychiatric Services Inpatient 30 Days Maximum per Benefit Period for treatment of psychiatric conditions other than serious mental illness. 30 days Maximum per Benefit Period for the treatment of Serious Mental Illness. Outpatient 60 Outpatient visits per Benefit Period; \$30 Maximum per visit 60 days Maximum per Benefit Period, up to a Maximum of \$30, per visit, for treatment of Serious Mental Illness. For the treatment of Serious Mental Illness, Inpatient days may be exchanged for additional Outpatient days; each Inpatient day may be exchanged for two Outpatient Facility/Professional visits or Partial Hospitalization days.	70%

Covered Services	Carrier Pays
<p>Alcohol and Drug Abuse and Dependency In the first instance or course of treatment, no deductible or co-payment shall be less favorable than those applied to similar classes or categories of treatment for physical illness.</p> <p>Inpatient Hospital Detoxification Maximum of 7 days per confinement and Lifetime Maximum of 4 confinements</p> <p>Hospital and Non-Hospital Residential Care Maximum of 30 days per Calendar Year and Lifetime Maximum of 90 days</p> <p>Outpatient Services 30 additional Full Session or Equivalent Partial Hospitalization Visits per Calendar Year.</p> <p>30 additional Full Session or Equivalent Partial Hospitalization Visits may be exchanged on a two-to-one basis to obtain up to 15 additional days of Non-Hospital Residential Care. Lifetime Maximum of 120 Visits</p>	<p>70%</p> <p>70%</p> <p>70%</p>
<p>Skilled Nursing Facility Pre-authorization of admission is required. 240 facility days per Benefit Period. Maximum of 35 professional visits per Benefit Period.</p>	<p>70%</p>
<p>Durable Medical/Surgical Equipment, Orthotic Appliances and Prosthetic Devices Pre-authorization is required on any DME, orthotic appliance or prosthetic device expense (single or aggregate) over \$1500</p>	<p>70%</p>
<p>Home Health Care Pre-authorization of services is required.</p>	<p>70%</p>
<p>Hospice Care</p>	<p>70%</p>
<p>Diabetic Education Program—exempt from Deductible</p>	<p>70%</p>

Covered Services	Carrier Pays
Blood	70%
Medical Foods and Nutritional Formulas (Deductibles do not apply to Medical Foods benefits.)	70%
Ambulance \$1,000 per Benefit Period for ground transportation	70%
Private Duty Nursing Pre-authorization of services is required.	70%
Preventive Care Services Office and Home visits Pediatric Preventive Care	70% 70%
Pediatric Immunizations —not subject to Deductible or Maximum amounts	70%
Routine Gynecological Examinations and Pap Smears —not subject to Deductible or Maximum amounts	70%
Mammography (not subject to Deductible amount)	70%
Diabetic Equipment and Supplies	70%

Eligibility Under The Plan

Who Is Eligible and When?

Effective Date: The date the Group agrees that all Eligible Persons may apply and become covered for the benefits as set forth in the Group Contract and described in this Booklet/Certificate.

Eligible Person

You are eligible to be covered under this Comprehensive Major Medical 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) when you are eligible for Employee coverage. An Eligible Dependent is defined as your spouse under a legally valid existing marriage, your unmarried children whom you continuously financially support or whose coverage is your responsibility under the terms of a qualified medical child support order (including stepchildren, children legally placed for adoption and your or your spouse's legally adopted children). To determine the limiting age when coverage ends for covered, unmarried children, including students enrolled full-time in an Accredited Educational Institution, refer to your Keystone member handbook.

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 your eligibility under the prior carrier's plan and also from time to time under this Plan.

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

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

As required by law, a Dependent child of a custodial parent covered under this Plan may be enrolled within 30 days of the Carrier's receipt of a qualified release or court order from the Group.

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

Your Comprehensive Major Medical Benefits

The following describes the benefits available to you and your eligible family members under the Plan. You are entitled to benefits for Covered Services when: (1) deemed Medically Necessary and/or Medically Appropriate and (2) billed for by a Provider. The Schedule of Benefits describes the benefits that will be payable for services and care provided by Providers and benefits that will be payable for those services.

Deductible

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 Covered Services. See the Schedule of Benefits section for the Deductible amount.

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

No more than three times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. This means that as soon as members of your Family incur the amount of charges for Covered Services shown in the Schedule of Benefits under "Family Deductible Amount", the Deductible obligation is met for the remainder of the Benefit Period for all Family members. While the charges for Covered Services incurred by any of your Family members will accrue towards the overall Family Deductible Amount, no Family member may contribute more than the individual Deductible amount to the overall Family Deductible amount for the Benefit Period.

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. Refer to 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 "Individual Out-of-Pocket Limit". See the Schedule of Benefits section for the Out-of-Pocket Coinsurance Limit amounts.

When your Individual Out-of-Pocket Coinsurance Limit is reached, the Carrier will pay 100% of your Covered Expenses for Covered Services incurred during the balance of the Benefit Period. There is an Individual Out-of-Pocket Limit and a Family Out-of-Pocket Limit. To meet the Family Out-of-Pocket Limit, the same rules apply as for meeting the Family Deductible Amount as explained above. In meeting the Family Out-of-Pocket Limit, not more than two times the Individual Out-of-Pocket Limit must be satisfied by the members enrolled under one 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 of Coinsurance toward the Family Out-of-Pocket Limit.

Inpatient Psychiatric services, Outpatient Psychiatric services, your Deductible, if any, and any other co-payments and penalties do not count toward the Out-of-Pocket Limit.

Lifetime Maximum Amount

The Lifetime Maximum amount is shown in the Schedule of Benefits. Once that amount of Covered Expense is incurred by an individual covered by the Plan, benefits will no longer be payable by the Carrier.

A portion of your Lifetime Maximum may be renewed whenever you furnish evidence of your insurability which is satisfactory to the Carrier. This renewal is not applicable to Psychiatric Care Services.

Payment Of Benefits

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

Member, Contracting and Participating Providers have contractual arrangements for the provision of services to you. Benefits will be provided as specified in the Schedule of Benefits for Covered Services or supplies rendered to you by a Member, Contracting or Participating Provider. The Carrier will compensate a Member, Contracting or Participating Provider in accordance with the rate of reimbursement determined by contract. Your out-of-pocket coinsurance costs will be less when you use these providers, because your coinsurance is calculated on lower contracted fees. The Carrier may reimburse Providers directly for the services covered under this program, or these Providers will, in most instances, submit claim forms for reimbursement on your behalf.

Non-Member, Non-Contracting and Non-Participating Providers do not have contractual arrangements for the provision of services to you. When Covered Services and supplies are rendered by these providers, your out-of-pocket coinsurance costs may be higher, since your coinsurance is calculated on the lesser of the reasonable and customary cost of the services provided and the Medicare Allowable Payment. (See the definition of "Covered Expense" in the "Definitions" section of this Booklet-Certificate). The Carrier will pay benefits to you directly, and you will be responsible for paying the Provider.

Assignment of Benefits to Providers

The right of a Covered Person to receive benefit payments under the coverage 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 coverage, as required by law.

When you need to file a claim, fill out the claim form and return it with your itemized bills to the Carrier no later than 90 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 90-day period, your benefits will not be reduced, but in no event will the Carrier be required to accept the claim more than 12 months after the end of the Benefit Period in which the Covered Services are rendered except in the absence of legal capacity of the claimant.

Covered Services

Inpatient Services—All Inpatient Admissions, (other than maternity and emergency admissions), must be pre-certified by the Carrier in accordance with the requirements contained in the Managed Care section of this booklet/certificate. Emergency admissions must be reviewed within 2 business days of the admission. A concurrent review is required for any continued length of stay beyond what has been Pre-Certified by the Carrier.

Hospital Services: Room and Board

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

1. 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 coverage in Hospitals having primarily private rooms;
2. A private room, when Medically Appropriate;
3. 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;
4. A bed in a general ward; and
5. Nursery facilities.

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 day.

Days available under this coverage shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (1) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (2) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

Hospital Services: 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:

1. Meals, including special meals or dietary services as required by the patient's condition;
2. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
3. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
4. Oxygen and oxygen therapy;

5. Administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as may be provided in paragraph entitled "Blood" in this Section;
6. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
7. Physical Therapy, Cardiac Rehabilitation Therapy, Respiratory Therapy, hydrotherapy, Speech Therapy, and/or Occupational Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
8. Radiation Therapy;
9. 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;
10. Use of Special Care Units, including but not limited to, Intensive or Coronary Care; and
11. Pre-admission testing.

Emergency Accident Services

Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of traumatic bodily injury resulting from an accident shall be covered if services are performed within 2 days of the date the accident occurred. Follow-up care provided in a Medically Appropriate setting shall also be covered if received within 14 days of the initial treatment, as specified above, for the Accidental Injury. Should any dispute arise as to whether an emergency condition existed, the determination by the Carrier shall be final.

Emergency Medical Services

Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of a medical condition with acute symptoms which would result in requiring immediate Medical Care shall be covered if services are performed within 2 days of the Medical Emergency. Medical Emergency shall include heart attacks, loss of consciousness or respiration, cardiovascular accident, convulsions or other such acute medical conditions as determined by the Carrier. Follow-up care shall also be covered if received within 14 days of the initial treatment, as specified above, of the Medical Emergency. Should any dispute arise as to whether an emergency condition existed, the determination by the Carrier shall be final.

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, any voluntary surgical procedure for sterilization, any surgery performed for the reversal of a sterilization procedure.

Hospital Admission for Dental Procedures or Dental Surgery

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. Dental procedures or Surgery performed during such a confinement will only be covered for the services described below under "Oral Surgery" and "Dental Services Related to Accidental Injury."

Oral Surgery

Dental or oral Surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Expense under the coverage only for: (1) treatment of diseases or injuries of the jaw; (2) treatment of fractures or dislocations; and (3) surgical removal of impacted teeth which are partially or completely covered by bone.

Dental Services related to Accidental Injury

Dental Services rendered by a Professional Provider and/or a Facility Provider which are required as a result of Accidental Injury to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

Assistant at Surgery

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered 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.

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.

Second Surgical Opinion (Voluntary)

Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an emergency or life threatening nature.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances the Covered Person will be eligible for a maximum of two such consultations

involving the elective surgical procedure in question, but limited to one consultation per consultant.

Medical Care

1. Inpatient 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.

a. Concurrent Care

Services may be provided to you as 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.

b. Consultations

Consultation services may be provided by a Professional Provider when you are an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility 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 consultation per consultant during any inpatient confinement.

2. Outpatient Medical Visits

Medical care rendered and billed by a Professional Provider to a Covered Person who is an Outpatient for a condition not related to Surgery, pregnancy, or Mental Illness, except as specifically provided. Benefits are provided for:

- a. Home, office and other outpatient visits;
- b. Medical Care visits and consultations for the examination, diagnosis, and treatment of an injury or illness (as specified in the Schedule of Benefits).

Diagnostic Services

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

1. Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;
2. Diagnostic laboratory and pathology tests;

3. Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures approved by the Carrier;
4. Allergy testing, consisting of percutaneous, intracutaneous and patch tests;

Therapy Services

Benefits shall be provided, subject to the Maximums specified in the Schedule of Benefits, for the following services prescribed by a Physician and performed by a Professional Provider and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

Chemotherapy

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents. 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 and only for those uses for which such drugs have been specifically approved by the Federal Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph.

Dialysis

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

Benefits will not be provided to the extent that benefits are payable by Medicare for persons who are Medicare eligible on the basis of End Stage Renal Disease (ESRD) and for whom Medicare must pay as primary carrier.

Radiation Therapy

The treatment of disease by X-ray, radium, or radioactive isotopes, including the cost of radioactive materials supplied and billed by the provider.

Physical Therapy

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

Cardiac Rehabilitation Therapy

Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise. Such therapy is covered for a patient recovering from myocardial infarction or a coronary bypass procedure, or who has been diagnosed with coronary disease, angina pectoris, valvular heart disease, exercise triggered cardiac arrhythmia or such other conditions as determined by the Carrier.

Respiratory Therapy

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

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.

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.

Pulmonary Rehabilitation Therapy

Includes treatment through a multidisciplinary program of physical therapy and an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

Infusion Therapy

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

Spinal Manipulations

Benefits will be provided 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.

Maternity Services

Obstetrical/Maternity Care

Services rendered in the care and management of a pregnancy for you, your spouse, or Dependent daughter are a Covered Expense under this program. Pre-certification of maternity care should occur within one month of the first prenatal visit to the Covered Person's 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 to a Professional Provider for a delivery shall include pre-and post-natal care.

Elective Abortions

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

Newborn Care

The newborn child of you, your spouse, or Dependent Daughter shall be entitled to benefits provided by this Plan from the date of birth up to a maximum of 31 days. Such coverage within the 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, pre-maturity and routine nursery care. The "Eligibility Under the Plan" section explains how coverage for a newborn may be continued beyond 31 days.

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 Psychiatric Services are subject to the Psychiatric limitations found in the Schedule of Benefits. When a Provider renders Medical Care, other than Psychiatric Care, for a Covered Person with Mental Illness or Serious Mental Illness, payment for such Medical Care will be based on the Medical benefits available instead of the Psychiatric benefits.

Inpatient Treatment

Benefits are provided, subject to the Benefit Period limitations and any applicable Plan Lifetime Maximum as stated in the Schedule of Benefits, for an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness.

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 and Outpatient Facility/Professional visits.

Inpatient visits for the treatment of Mental Illness, Serious Mental Illness, Drug and Alcohol Abuse are covered when performed by a Professional Provider.

Covered services include treatments such as: Psychiatric Visits, Psychiatric Consultations, Individual and Group Psychotherapy, Electroconvulsive Therapy, Psychological Testing, Psychopharmacologic Management, and Psychoanalysis.

Outpatient Treatment

Benefits are provided, subject to the Benefit Period limitations and any applicable Plan Lifetime Maximum as shown in the Schedule of Benefits, for Outpatient treatment of Mental Illness and Serious Mental Illness.

Covered services include treatments such as: Psychiatric Visits, Psychiatric Consultations, Individual and Group Psychotherapy, Electroconvulsive Therapy, Psychological Testing, Psychopharmacologic Management, and Psychoanalysis.

Family counseling, counseling with family members to assist in the Covered Person's diagnosis and treatment, is covered when performed by a Professional Provider. (See item (4) below).

Benefits are not payable for the following services:

1. Vocational or religious counseling;
2. Activities that are primarily of an educational nature;
3. Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad based professional consensus, such as, but

not limited to Primal therapy, Rolfing or structural integration, Bioenergetic therapy, and Obesity control therapy;

4. Facility Provider charges for family counseling services.

Benefit Period Maximums for Psychiatric Care

All Inpatient and/or Outpatient psychiatric services for Mental Illness and Serious Mental Illness are covered up to the Maximum day and visit limitations per Benefit Period as specified in the Schedule of Benefits.

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.

Prior to qualifying for benefits for inpatient detoxification, rehabilitation, hospital or non-hospital residential treatment, or outpatient alcohol or drug services, a physician or licensed psychologist must pre-certify that the covered person is suffering from alcohol or drug abuse or dependency. This requirement is in addition to the provisions for hospital pre-certification contained in the General Information.

Inpatient Detoxification

Inpatient covered Services for Detoxification shall be covered for up to 7 days per admission for Detoxification with a Lifetime Maximum of 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.

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 the Contract, but services are limited to 30 days per calendar year.

Additional days may be available as specified in "Outpatient Alcohol or Drug Services", below. There is a lifetime Maximum of 90 days per Covered Person.

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. Psychiatric, psychological and medical laboratory testing;
5. Drugs, medicines, use of equipment and supplies.

Outpatient Alcohol or Drug Services

Outpatient Alcohol or Drug Services shall be covered up to a maximum of 30 full Outpatient session visits or an equivalent number of Partial Hospitalization visits per calendar year.

Benefits are available for an additional 30 separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a 2 to 1 basis to receive up to 15 more days of Non-Hospital Residential Alcohol or Drug Treatment (i.e., the Covered Person may trade off on a 2 for 1 basis up to 30 separate sessions of Outpatient services per year in order to receive up to 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.

There is a Lifetime Maximum of 120 full session visits or an equivalent number of Partial Hospitalization visits per Covered Person.

Covered services include:

1. Physician, psychologist, nurse, certified addictions counselor and trained staff services;
2. Rehabilitation therapy and counseling;
3. Family counseling and intervention;
4. Psychiatric, psychological and medical laboratory testing;
5. Drugs, medicines, use of equipment and supplies.

Skilled Nursing Facility

Benefits are provided for a Skilled Nursing Facility, when Medically Appropriate as determined by the Carrier, up to the Maximum limits, if applicable, 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.

No benefits are payable:

1. 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;
2. 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;

3. For the treatment of alcohol and drug addiction, and Mental Illness.

Durable Medical Equipment, Orthotic Appliances and Prosthetic Devices

Subject to any Pre-authorization requirements and Maximum limits set forth in the Schedule of Benefits, the following benefits are provided:

1. Durable Medical Equipment

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.

2. Orthotic Appliances and Prosthetic Devices

Expenses incurred for orthotic appliances and prosthetic devices for an illness or injury.

Medical expenses for orthotic appliances and 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, the following:

- a. The purchase, fitting, necessary adjustments and repairs of prosthetic devices and supplies 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
- b. Orthopedic braces necessary for alleviation or correction of conditions due to injury, illness, or congenital deformities. However, corrective shoes are excluded unless (1) such shoes are attached to orthopedic braces; or (2) such shoes or other podiatric appliances are used for the prevention of complications associated with diabetes.
- c. Eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular Surgery (i.e. cataract Surgery) or injury; pinhole glasses prescribed for use after Surgery for detached retina; lenses prescribed in lieu of Surgery for the following:
 1. Contact lenses used for treatment of infantile glaucoma;
 2. Corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
 3. Scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
 4. Corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

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

Benefits are not payable for dental appliances, for wigs, or eyeglasses except as specified in Item (c) above.

Home Health Care

Subject to any Maximum limits shown in the Schedule of Benefits, 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;
6. Care within 48 hours following release from an Inpatient admission when the discharge occurs within 48 hours following a mastectomy.

With respect to well mother/well baby care following early release from an inpatient maternity stay, Home Health Care services must be provided within 48 hours if discharge occurs earlier than 48 hours of a vaginal delivery or 96 hours of a cesarean delivery. No Deductible, Co-payment 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. 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. This means that leaving the home could be harmful to such person, would involve a considerable and taxing effort, and that the Covered Person is unable to use transportation without another's assistance.

Exclusions:

No home health care benefits will be provided for services and supplies in connection with home health services for the following:

1. Services which exceed the specified limits of liability;
2. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
3. Private Duty Nurses;
4. Rental or purchase of Durable Medical Equipment;
5. 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;

6. Prescription Drugs;
7. Services provided by a member of the patient's family or the family of the patient's spouse;
8. Patient's transportation, including services provided by voluntary ambulance associations for which the patient is not obligated to pay;
9. Emergency or non-emergency ambulance services;
10. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
11. Services provided to individuals who are not essentially homebound for medical reasons; and
12. Visits by any Provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the Provider.

Hospice Services

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 rather than other types of care, the Covered Person shall be eligible for Hospice benefits when provided by a Hospice.

Respite Care—When Hospice Care is provided in the home, 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 patient's home. Benefits are payable according to the Maximums set forth in the Schedule of Benefits.

Benefits for Covered Hospice Services shall be provided until the earlier of patient's death or discharge from the Hospice. These benefits are in addition to and not in lieu of any other benefits under this coverage.

Special Exclusions:

The Hospice Care program must deliver Hospice Care in accordance with a treatment plan approved by and periodically reviewed by the Carrier.

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 patient's personal, legal and financial affairs such as preparation and execution of a will or other dispositions of personal and real property); and
4. Care provided by family members, relatives, and friends.

Outpatient 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 patient's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Member Hospital or other entity under contract with the Carrier. 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 upon the certification programs for outpatient diabetes education developed by the American Diabetes Association and the Pennsylvania Department of Health.

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

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

Blood

Benefits are provided for whole blood, blood plasma, the administration of blood, blood processing, and blood derivatives, which are not classified as drugs in the official formularies, whole blood and blood plasma which have not been replaced by a donor.

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.

Ambulance

Benefits are payable for ambulance services, which the Carrier determines to be Medically Appropriate/Medically Necessary, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured. These benefits are subject to the Maximum specified in the Schedule of Benefits. The Ambulance must be transporting the Covered Person:

1. From a Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital;
2. Between Hospital and Skilled Nursing Facility or between Hospitals.

If there is no Hospital in the local area that can provide services Medically Necessary/Medically Appropriate for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.

Air ambulance transportation benefits are payable only if the Carrier determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air instead of another means of transportation. Benefits for the air ambulance may not exceed the Maximum shown in the Schedule of Benefits.

Outpatient Private Duty Nursing Services

Benefits shall be provided up to the Maximum, if applicable, specified in the Schedule of Benefits for Outpatient services for Private Duty Nursing services performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician.

Private duty nursing services must be Pre-Authorized by the Carrier. No benefit shall be payable for such expenses if the Covered Person does not obtain Pre-Authorization. All nursing services must be 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;
3. Services provided by a home health aide or a nurse's aide; and
4. Services which have not been Pre-Authorized by the Carrier.

Transplant Services

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

3. When only the donor is a Covered Person, the donor is entitled to the benefits of the program. The 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 available to the recipient. No benefits will be provided to the non-Covered Person transplant recipient.
4. If any organ or tissue is sold rather than donated to the recipient who is a Covered Person, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and are covered up to the Covered Person's (recipient's) Coverage limit.

Preventive Care Services

Home and Office Visits, Outpatient Consultations—Medical care visits for the examination, diagnosis and treatment of an illness or injury.

Preventive Pediatric and Adult Care

“Preventive Services” generally describes health care services performed to catch the early-warning signs of health problems. These services are performed when you have no symptoms of disease. Services performed to treat an illness or disease are not covered as Preventive Care under the Primary Care Services section of this booklet/certificate.

Preventive Pediatric Care—Well baby care including routine Physician examinations and routine diagnostic tests. Benefits are limited to Covered Dependents under 18 years of age in accordance with the schedule shown below.

Benefits are provided for services when the service is received during the ages listed below. When a range is given, (i.e., 2-3 months) the dash indicates that coverage is available for one service from 2 months through 3 months of age.

Routine History, Physical Examination—Generally includes a medical history, height and weight measurement, physical examination, and counseling.

18 exams up to age 17—one exam during each of the following age groupings:

0-1 month	15-17 months	6-7 years
2-3 months	18-24 months	8-9 years
4-5 months	2 years	10-11 years
6-8 months	3 years	12-13 years
9-11 months	4 years	14-15 years
12-14 months	5 years	16-17 years

Urinalysis—This test detects numerous abnormalities. Children are covered for:

- One test between birth-age 2
- One test between age 12-17 years

Hemoglobin/Hematocrit—A blood test which measures the size, shape, number and content of red blood cells. Children are covered for:

- One service between birth-12 months
- One service between age 1-4 years
- One service between age 5-12 years
- One service between age 14-17 years

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 test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one test and immunization between age 11-17 years

Pediatric Immunizations—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 you and your spouse until you reach age 21 and to Dependent children. This benefit is not subject to a deductible or dollar limits.

Routine Gynecological Examination and Pap Smears—Female Covered Persons are covered for one annual gynecological examination, 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. This benefit is not subject to a deductible.

Screening Mammograms—Coverage is provided for one screening mammogram per calendar year for females 40 years of age and older, and any screening mammogram for females under age 40 when recommended by a Physician;

Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

Adult Preventive Care—periodic well-person routine immunizations and examinations, including physical examination, complete medical history, plus necessary Diagnostic Services. Benefits are limited to Covered Persons 18 years of age and older in accordance with the following schedule:

Routine History, Physical Examination—Generally includes a medical history, height and weight measurement, physical examination, and counseling.

One exam every three years between age 18-49
One annual exam, beginning at age 50

Fecal Occult Blood Test—A test for the presence of blood in the feces which is an early indicator of colon-rectal cancer.

One test per year, beginning at age 50

Blood Cholesterol Test—A blood test which measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.

One test every four years between age 18-65
One test between age 66-67
One test between age 68-69

Adult Tetanus Toxoid (TD)—An immunization which provides immunity against tetanus and diphtheria.

One service every ten years from age 18

Rubella Titer Test and Rubella Immunization—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 test is recommended when it is unsure whether the adult has ever been immunized.

One test and immunization between age 18-49

Influenza Vaccine—A vaccine against influenza type A and B viruses.

One vaccine annually beginning at age 65

Pneumococcal Vaccine—A vaccine against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.

One vaccine every five years, beginning at age 64

Therapeutic Injections and Allergy Injections—Benefits are payable for allergy injections and therapeutic injections required in the diagnosis and treatment of an injury or illness.

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 services is subject to change. Therefore, the Carrier reserves the right to modify this schedule 60 days after written notice has been given to the Group.

Medical Foods and Nutritional Formulas

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

Benefits are 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 program.

Diabetic Equipment and Supplies

Benefits shall be provided for the following diabetic equipment and diabetic supplies furnished by a Durable Medical Equipment Supplier.

1. Diabetic Equipment

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

*Pre-certification is required for the purchase of equipment that exceeds \$1,500 in purchase price.

2. Diabetic Supplies

- a. blood testing strips;
- b. visual reading and urine test strips;
- c. insulin syringes;
- d. lancets and lancet devices;
- e. monitor supplies; and
- f. glucagon emergency kits.

Insulin, insulin analogs and pharmacological agents to control blood sugar are not covered as Self-referred benefits. They are covered as Referred benefits only.

Exclusions

Except as specifically provided under the coverage, no benefits will be provided for services, supplies or charges:

- Which are not Medically Necessary/Medically Appropriate as determined by the Carrier for the diagnosis or treatment of illness or injury;
- Which are Experimental or 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 your coverage except as provided in the "General Information" section of this booklet/certificate;
- For any loss sustained or expenses incurred during military service while on active duty; 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;
- 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;
- For payment made under Medicare when Medicare is primary or would have been made if the Covered Person had enrolled for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Group is obligated by law to offer the Covered Person all the benefits of this coverage and the Covered Person so elects this coverage as primary;
- 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 benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- Which are not billed and performed by a Provider unless otherwise indicated;
- Which are submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient;
- Rendered by a member of the 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 the coverage;
- 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 and defined under the subsection entitled "Surgical Services";
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For music therapy;
- 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 marriage counseling;
- For Custodial Care, domiciliary care or rest cures;
- For equipment costs 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 by the Carrier;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as specifically stated in the Group Contract. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants, and treatment of periodontal disease unless otherwise indicated. This exclusion does not apply to orthodontic treatment for congenital cleft palates as provided for and defined under the Surgical Services benefit;
- For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or any non-surgical method to alter vertical dimension;
- For palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For supportive devices for the foot (orthotics), except for orthotics and podiatric appliances for the prevention of complications associated with diabetes;

- For hearing aids or hearing examinations or tests for the prescription or fitting of hearing aids;
- For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;
- For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs, chairlifts, elevators, spa or health club memberships, whether or not recommended by a Provider;
- 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 preventive services, except as specifically provided under the section of this booklet/certificate entitled "Covered Services", subsection "Preventive Care Services";
- For routine or periodic physical examinations and diagnostic studies, except for routine gynecological examinations as provided herein;
- For weight reduction and premarital blood tests;
- For diagnostic screening examinations, except for mammograms and pap smears as provided under the Plan;
- For charges in excess of the Reasonable and Customary amount for the services or supplies furnished.
- For acupuncture;
- For travel, whether or not it has been recommended by a Professional Provider;
- 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 patient's relatives, or Hospital charges for a patient's relatives or guests, except as may be specifically provided under the coverage;
- For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits, and home blood pressure machines, except for Covered Persons with pregnancy-induced hypertension and hypertension complicated by pregnancy;

- For Prescription Drugs;
- For any medication other than Prescription Drugs, unless administered during an inpatient admission;
- For amino acid supplements, appetite suppressants or nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy, or protein allergy. This exclusion does not apply to nutritional supplements as provided for and defined in the “Medical Foods and Nutritional Formulas” subsection of the Covered Services section of this booklet/certificate;
- For Inpatient Private Duty Nursing services;
- Any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems or mental retardation; or treatment or care to effect environmental or social change;
- For charges incurred for expenses in excess of Benefit Maximums as specified in the Schedule of Benefits;
- For research studies;
- For Maintenance of chronic conditions, injuries or illness when response to treatment has reached the maximum therapeutic level, no additional functional improvement can be demonstrated or anticipated, and continuation of the service will be of no therapeutic value to the Covered Person;
- For injury sustained while (a) participating in any interscholastic, intercollegiate, or professional sport contest or competition; (b) traveling to or from such sport contest or competition and a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
- For any other service or treatment except as provided in this booklet/certificate;
- Which are paid to or on behalf of a Covered Person by a Keystone HMO contract under which the Covered Person is enrolled as an Employee or Eligible Dependent of an Enrolled Group, when that person is also concurrently covered as an Employee or Dependent of that same Enrolled Group under this coverage. Any co-payments or deductible amounts required by the Keystone HMO contract are also excluded.

General Information

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 shall be conclusive.

When You Terminate Employment—Continuation Of Coverage Provisions—COBRA

This may or may not apply to your group. Please contact your employer to find out whether or not you are covered under this provision.

For purposes of this subsection of your booklet/certificate, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for group health benefits under this Plan as:

1. You, an active, 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 continuee.

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 continuee.

If An Employee Terminates Employment or Has a Reduction of Work Hours

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 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 continuee 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 Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified continuee'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 60 days of that date, the qualified continuee and any other affected qualified continuees may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security's determination of the qualified continuee's disability before the earlier of:

1. The end of the 18 month continuation period; and
2. 60 days after the date the qualified continuee is determined to be disabled.

If, during the 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, the qualified continuee must notify the Plan Administrator within 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 die, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 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 continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 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 continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 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 continuees other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 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 continuee. The continuation can last for up to 36 months, subject to the "When Continuation Ends" paragraph of this subsection.

Concurrent Continuations

If your Dependent who is a qualified continuee 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, the Dependent may elect to extend his or her 18 month continuation

period to up to 36 months, if during the 18 month continuation period the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

The Qualified Continuee'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; or
2. Your Dependent child's loss of Dependent eligibility, as defined in this booklet/certificate.

The notice must be given to the Plan Administrator within 60 days of either of these events.

In addition, a disabled qualified continuee must notify the Plan Administrator, in writing, of any final determination that the qualified continuee 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 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; or
3. Your entitlement to Medicare.

The notice must be given to the Plan Administrator within 60 days of any of these events.

The Plan Administrator's Responsibilities

The Plan Administrator must notify the qualified continuee, 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 continuee within 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 continuee notifies the Plan Administrator, in writing, of your legal 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 continuee's continued group health benefits to the same extent as, and in the place of, the Plan, if:

1. The Employer fails to remit a qualified continuee's timely premium payment to the Plan on time, thereby causing the qualified continuee's group health benefit to end; or
2. The Plan Administrator fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

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

The subsequent premiums must be paid to the Plan Administrator by the qualified continuee, 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 continuee 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 continuees who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified continuee 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 continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits under this coverage 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 18 month period which starts on the date the group health benefits would otherwise end;
2. With respect to a disabled qualified continuee and his or her family members who are qualified continuees who have elected an additional 11 months of continuation, the earlier of:
 1. The end of the 29 month period which starts on the date the group health benefits would otherwise end; or
 2. The first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee 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 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,
 1. *After* your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
 2. *Before*, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 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 36 months from the date you become entitled to Medicare.
5. The date this coverage 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 continuee 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 your 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.

Termination Of Coverage And The Right To Conversion

When your coverage as described in this booklet terminates, the privilege of conversion shall be available to you if you have been continuously covered under the group contract for at least three months prior to the termination. This privilege is also available to an Eligible Dependent whose coverage terminates because of your death, a change in your employment status, divorce of your spouse or change in your Dependent's eligibility status.

The privilege of conversion is not available to you or your Eligible Dependent if one of the following applies:

1. Within 31 days of the termination of this coverage, the person is eligible for coverage provided by another group contract, whether provided by this Plan or another organization; or
2. The issuing of the conversion contract would result in over-insurance due to the Covered Person being eligible for another health care program which is available from the group where the covered person is employed or with which the Covered Person is affiliated; or
3. Termination of this coverage resulted from failure to pay the required contribution when due.

Application for the conversion contract and payment of the first premium must be made within 31 days of termination of this coverage, except the 31 day period is subject to the Notice of Conversion provision set forth below. The conversion coverage shall cover you and your Eligible Dependents who were covered by this coverage on the date of termination. The conversion coverage may be different from this coverage. Evidence of insurability is not required.

Notice of Conversion:

Written notice of termination shall be given within fifteen days before or after the date of termination of the group coverage, provided that if such notice is given more than fifteen days but less than ninety days after the date of termination of group coverage, the time allowed for the exercise of the privilege of conversion shall be extended for fifteen days after the giving of such notice. If such notice is not given within ninety days after the date of termination of group coverage, the time allowed for the exercise of the conversion privilege shall expire at the end of the ninety days. It is the responsibility of your employer to provide notice of conversion and its duration to you.

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

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

Coverage under this Plan will apply during an extension as if the person were still a Covered Person, except any reinstatement of a person's Lifetime Maximum amount will not be allowed under the Reinstatement provisions of the Plan. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for the person through the Plan by the Group. Continuation of coverage is subject to payment of the applicable premium.

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 coverage are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person's termination under the Group Contract, 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 the Group Contract to be not more than 60 days before the first day of the month in which the Group notified the Carrier of such termination.

Continuation Of Incapacitated Child

If an unmarried child is incapable of self-support because of mental or physical incapacity and is Dependent on you for over half of his support, you may apply to the Carrier to continue coverage of such child under the 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 the limiting age for the termination of dependent children.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining the limiting 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 the limiting 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.

Timely Filing

The Carrier will not be liable unless proper notice is furnished to the Carrier that Covered Services have been rendered to a Covered Person. Written notice must be given within 90 days after completion of the Covered Services. The notice must include the date and information required by the 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, except the Carrier will not be required to accept notice more than 24 months after the end of the Benefit Period in which the Covered Services are rendered except in the absence of legal capacity of the claimant.

Release Of Information

Each 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 the identity of any Employee or other patient 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.

Limitation Of Actions

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

Employee/Provider Relationship

1. The choice of a Provider is solely yours.
2. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by persons covered under the 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.

Subrogation

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

You 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.

Coordination Of Benefits

This Plan's Coordination of Benefits provision is designed to conserve funds associated with health care.

1. Definitions

In addition to the Definitions of this Plan for purposes of its 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 \$100), blanket (except student accident) or franchise insurance coverage;
- b. The Plan, health maintenance organization and other prepayment coverage;
- c. Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
- d. Coverage under any tax supported or government program to the extent permitted by law.

The definition "Plan" does not include any group-type plan that provides hospital indemnity benefits of less than \$100 per day.

2. Determination of Benefits

Coordination 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 does not agree on the order of benefits, this rule does not apply.
- d. If none of the above rules applies, 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 a Carrier payment exceed the amount that would have been payable under this Plan if the Carrier was 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 those related to second surgical opinion penalties, and penalties and increased coinsurance related to pre-certification 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.

4. 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:

- a. the person the Carrier has paid or for whom they have paid;
- b. insurance companies; or
- c. 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.

BlueCard Program

When you obtain health care services through BlueCard outside the geographic area QCC Insurance Company ("QCC") serves, the amount you pay for Covered Services is calculated on the lower of:

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

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your

liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, QCC would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Managed Care

Certain services must be pre-certified by the designated agent for the Carrier in order for you to receive full benefits. Pre-certification is required for all inpatient Hospital admissions, psychiatric care, treatment of substance abuse, durable medical equipment (above the rental or purchase price of \$1,500) private duty nursing services, admissions to skilled nursing facilities and home health care. Pre-certification is not required for maternity inpatient admissions. The use of a Member or Contracting Provider will ensure that the pre-certification process will be initiated in your behalf. However, if you do not use a Member or Contracting Provider, you will be responsible for obtaining the necessary approval.

Pre-Admission Review For Inpatient Stays

All Inpatient Admissions, with the exception of maternity and emergency admissions must be pre-authorized by the Carrier or its designated agent in accordance with the standards of the Carrier of the Medical Appropriateness of the admission. For other than maternity or emergency admissions, you are responsible to contact or have the admitting Physician or Hospital contact the Carrier prior to the admission. At or before the time of admission, the Hospital will verify the pre-certification with the Carrier. The Carrier will not authorize the Hospital admission if pre-certification is required and is not obtained in advance.

If prior approval for a Medically Appropriate Inpatient Admission has not been certified as required under this coverage, there will be a penalty for non-compliance and the following amount will be deemed not to be Covered Services under this contract: \$700. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

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

If pre-admission certification is denied, the Covered Person, the Physician, or the Hospital 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 Hospital will be so notified.

The Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for admissions to Member Hospitals which fail to conform to the above pre-certification requirements unless (1) the Hospital provides prior written notice that the admission will not be paid by the Carrier, and (2) 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 Hospital admission.

Emergency Admission Review

You, your admitting physician or the Hospital is responsible for notifying the Carrier of an emergency admission for yourself or a Dependent within two 2 business days of the admission, or as soon as reasonably possible, as determined by the Carrier.

Failure to initiate emergency admission review will result in a reduction in Hospital benefits of \$700. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

If a Covered Person elects to remain hospitalized after the Carrier has determined that a Hospital level of care is not Medically Appropriate, the Covered Person will be financially liable for non-covered Inpatient charges from the date of written notification.

Concurrent Review

The designated agent assigns an estimated length of stay for all approved Inpatient Hospital admissions. It also approves admissions to Skilled Nursing Facilities and other types of care provided by other Facility Providers and Professional Providers as provided for in this Section.

Concurrent review of an approved admission or plan of treatment may result in an approval of a request for an extension of approved care. The designated agent will verbally inform the Provider of the approval of any additional care as a result of the concurrent review. It will also continue to monitor extensions of care to determine when further Covered Services are no longer Medically Necessary/Medically Appropriate. The written determination that Covered Services are no longer Medically Necessary/Medically Appropriate will result in the termination of benefits payable for the treatment of the illness or injury.

Individual Case Management

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

The Carrier will identify cases where ICM may be appropriate for a Covered Person who suffers from a catastrophic illness or injury. Then the Carrier will assess the Covered Person's anticipated medical needs, after consultation with the attending Physician, the Covered Person and his/her family, where necessary.

However, ICM will be made available to the Covered Person if, and only if, all of the following criteria are met:

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

Following implementation, ICM will continue until:

1. The patient's medical goals (as identified in the approved Plan of Treatment) are met and additional services are not Medically Necessary/Medically Appropriate, as determined by the Carrier;
2. In the opinion of the attending Physician, the patient's condition no longer requires the services provided under the approved Plan of Treatment, and a different course of treatment is appropriate;

3. The patient exhausts benefits provided under this coverage or under the approved Plan of Treatment; or
4. The contractholder, the patient (or the patient's family, where necessary) or the Carrier terminates ICM upon appropriate notice.

Pre-Authorization For Private Duty Nursing Services, Skilled Nursing Facility Admissions And Home Health Care

Private Duty Nursing Services:

Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) must be submitted, in advance, to the Carrier for medical review to determine Medical Appropriateness/Medical Necessity and eligibility under terms of this Plan.

No benefits will be provided for nursing services which have not been Pre-Authorized by the Carrier.

Skilled Nursing Facility:

All admissions to Member Skilled Nursing Facilities should be pre-authorized by the Carrier to determine the Medical Appropriateness of the admission. Either the Physician, the Skilled Nursing Facility or the Covered Person should contact the Carrier prior to admission. If such prior approval is not obtained and the Covered Person is admitted, then benefits will be provided for Medically Appropriate services, but services which are not determined to be Medically Appropriate will not be paid.

Home Health Care

All services, with the exception of well mother/well baby visits provided because of early inpatient discharge, provided by Home Health Care Agencies should be pre-authorized by the Carrier to determine whether services are Medically Appropriate/Medically Necessary. Either the Physician, the Home Health Agency or the Covered Person should contact the Carrier prior to the provision of services. If such prior approval is not obtained and the Covered Person receives home health care, then benefits will be provided for Medically Appropriate/Medically Necessary care, but services which are not determined to be Medically Appropriate/Medically Necessary will not be paid.

Approval Process

The Carrier must be contacted to review all requests for Pre-certification approval.

Appeal Procedure

Refer to the Keystone Member Handbook for a description of appeal procedures.

Definitions

For the purposes of this booklet/certificate, the terms below have the following meaning.

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

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

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

AMBULATORY SURGICAL FACILITY—a Facility Provider, with an organized staff of Physicians, which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health care, Inc., or by the 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—means an individual or entity that provides Ambulance Services, renal dialysis services or home infusion services or is in the business of renting and selling Durable Medical Equipment and supplies, orthotic and prosthetic supplies.

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

APPLICANT AND EMPLOYEE/MEMBER—shall mean you, the Employee/Member, who applies for coverage under the Plan.

APPLICATION AND APPLICATION CARD—shall mean your request for coverage, either written or via electronic transfer, 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—means a Facility Provider approved by the Carrier which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a Physician or a licensed certified nurse midwife.

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

COINSURANCE—means the percentage of the Covered Expenses which must be paid by the Covered Person.

CONTRACTING ANCILLARY PROVIDER—means an Ancillary Provider which has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

CO-PAYMENT—a specified amount of expenses applied to a specific Covered Service for which you are responsible per Covered Service.

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

- a. For services rendered by a Facility Provider, the term "Covered Expense" may not refer to the actual amount(s) paid by the Plan to the Provider(s). Rather, "Covered Expense" means the following:
 1. For services rendered by a Member Facility Provider, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Plan Wide Discount in effect at the time the services are rendered;
 2. For services rendered by a Non-Member Facility Provider, "Covered Expense" means the lesser of the: (1) Facility Provider's charges, (2) Medicare Allowable Payment, or (3) Reasonable and Customary amount, for the Covered Services.
- b. For services rendered by a Professional Provider, "Covered Expense" means the following:
 1. For services rendered by a Participating Professional Provider, "Covered Expense" means the amount negotiated with the Professional Provider, or the charge, whichever is less;
 2. For services rendered by a Non-Participating Professional Provider, "Covered Expense" means the Reasonable and Customary amount, or the charge, whichever is less.
- c. For services rendered by Ancillary Providers, "Covered Expense" means the following:

1. For services rendered by a Contracting Ancillary Provider, "Covered Expense" means the amount negotiated with the Provider, or the charge, whichever is less;
2. For services rendered by a Non-contracting Ancillary Provider, "Covered Expense" means the lesser of the: (1) Provider's charges, (2) Medicare Allowable Payment, or (3) Reasonable and Customary amount, for the Covered Service.

COVERED PERSON—means you and your Eligible Dependents. 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.

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.

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

DEPENDENT—means:

- a. Your spouse under a legally valid existing marriage;
- b. Your unmarried child who is continuously financially supported by you or whose coverage is your responsibility under the terms of a qualified medical child support order, (including any stepchild or legally adopted child or child pending formal adoption). To determine the limiting age for covered, unmarried children, including students enrolled full-time in an Accredited Educational Institution, refer to your Keystone member handbook; and
- c. Eligibility will be continued past the limiting age for unmarried children who, as determined by the Carrier, are incapable of self-support due to physical or mental incapacitation.

Dependent does not include a person who is: (1) an eligible Employee of the Enrolled Group; or (2) a member of the armed forces.

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

DURABLE MEDICAL EQUIPMENT—is equipment which:

- a. Can withstand repeated use;

- b. Is primarily and customarily used to serve a medical purpose;
- c. Generally is not useful to a person in the absence of an illness or injury; and
- d. Is appropriate for use in the home.

EFFECTIVE DATE—according to the Eligibility Section, the date on which your coverage begins under this Plan.

EMERGENCY CARE—the initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury. This shall not include treatment for an occupational injury for which benefits are provided under any Workers' Compensation Law or any similar Occupational Disease Law. The symptoms or injury must be of sufficient severity to warrant immediate attention.

- a. Emergency Accident Services—the initial treatment of traumatic bodily injuries resulting from an accident.
- b. Emergency Medical Services—the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:
 - 1. Permanently placing the Covered Person's health in jeopardy;
 - 2. Causing other serious medical consequences;
 - 3. Causing serious impairment to bodily functions; or
 - 4. Causing serious and permanent dysfunction of any bodily organ or part.

Should any dispute arise as to whether an emergency condition existed, the determination by the Carrier shall be final.

EMPLOYEE/MEMBER—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 through a tube into the stomach or small intestine.

EXPERIMENTAL OR INVESTIGATIVE—the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Carrier, relying on the advice of the general medical community which includes, but is not limited, to medical consultants, peer reviewed medical journals and/or governmental regulations, does not accept as standard medical treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time services were rendered.

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

- Ambulatory Surgical Facility
- Birth Center
- Freestanding Dialysis Facility

- Free-Standing Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Non-Hospital Facility
- Psychiatric Hospital
- Rehabilitation Hospital
- Residential Treatment Facility
- Short Procedure Unit
- Skilled Nursing Facility

FAMILY COVERAGE—for you and one or more of your Dependents.

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

FREE-STANDING DIALYSIS FACILITY—a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the 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)—means a group of Employees which has been accepted by the Carrier, consisting of all those active Employees whose charges are remitted by the Applicant’s Agent together with all the Employees and Dependents, listed on the Application Cards or amendments thereof, who have been accepted by the Carrier.

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

HOSPITAL—means 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 Alcoholism or Drug Abuse;
- Place for provision of rehabilitation care;
- Place for treatment of pulmonary tuberculosis;
- Place for provision of Hospice care.

IDENTIFICATION CARD—shall mean the currently effective card issued to you by the Carrier.

IMMEDIATE FAMILY—your spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

INCURRED—a charge shall be considered incurred on the date a 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.

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

INPATIENT CARE FOR ALCOHOL OR DRUG ABUSE—means the provision of medical, nursing, counseling or therapeutic services twenty-four hours a day in a Hospital or Non-Hospital Facility, according to individual treatment plans. This Facility must also meet the minimum standards for such facilities set by the Pennsylvania Department of Health, the Pennsylvania Office of Drug and Alcohol Programs, or other appropriate governmental agency.

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

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

MAXIMUM—a limit on the amount of Covered Services that you may receive. This could be expressed in dollars, number of days, or number of services for a specified period of time.

- a. **Benefit Maximum**—the greatest amount payable by the Carrier for a specific Covered Service.
- b. **Lifetime Maximum**—the greatest amount payable by the Carrier in a Covered Person's Lifetime.

MEDICAL CARE—professional services rendered by a 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 and homocystinuria.

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

- a. Ordered by a Professional Provider or other appropriately licensed health care professional; and
- b. Required for the diagnosis, or the direct care and treatment of the Covered Person's condition, illness, disease or injury; and
- c. Appropriate for the symptoms and diagnosis or treatment of the Covered Person's condition, illness, disease or injury; and
- d. In accordance with standards of good medical practice as generally recognized and accepted by the medical community;
- e. Not primarily for the convenience of the Covered Person's Family, or of the Facility Provider or Professional Provider; and
- f. The most efficient and economical supply or level of service that can safely be provided to the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as a bed patient due to the nature of the services rendered for the Covered Person's condition, and the Covered Person cannot receive safe and adequate care in some other setting without adversely affecting the Covered Person's condition or quality of Medical Care.

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

- a. Appropriate for the symptoms and diagnosis or treatment of the Covered Person's condition, illness, disease or injury;
- b. Provided for the diagnosis, or the direct care and treatment of the Covered Person's condition, illness, disease or injury;
- c. In accordance with current standards of good medical practice;
- d. Not primarily for the convenience of the Covered Person, or the Covered Person's Professional Provider; and
- e. The most appropriate supply or level of service that can safely be provided to the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as a bed patient due to the nature of the services rendered for the Covered Person's condition, and the Covered Person cannot receive safe or adequate care as an Outpatient.

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 the Covered Service or supply.

MEMBER FACILITY PROVIDER—means a Facility Provider approved by the Carrier for the provision of Covered Services to Covered Persons for a rate of reimbursement which is determined by contract.

MEMBER HOME HEALTH CARE AGENCY—means a Home Health Care Agency approved by the Carrier for the provision of Covered Services to Covered Persons for a rate of reimbursement which is determined by contract.

MEMBER HOSPICE—means a Hospice approved by the Carrier for the provision of Hospice services to Covered Persons for a rate of reimbursement which is determined by contract.

MEMBER HOSPITAL—means a Hospital that is approved by the Carrier for the provision of Covered Services to Covered Persons for a rate of reimbursement which is determined

MEMBER OUTPATIENT PSYCHIATRIC FACILITY—means a Facility Provider which is approved by the Carrier for the provision of Outpatient diagnostic and therapeutic psychiatric services to Covered Persons for a rate of reimbursement which is determined by contract.

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

NON-CONTRACTING ANCILLARY PROVIDER—an Ancillary Provider that has not agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

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

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

NON-MEMBER FACILITY PROVIDER—means a Facility Provider that has not agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

NON-MEMBER HOSPICE—means a Hospice which has not agreed to a rate of reimbursement determined by contract for the provision of Hospice services to Covered Persons.

NON-MEMBER HOSPITAL—means a Hospital which has not agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

NON-MEMBER OUTPATIENT PSYCHIATRIC FACILITY—means a Facility Provider which has not agreed to a rate of reimbursement determined by contract for the provision of Outpatient diagnostic and therapeutic psychiatric services to Covered Persons.

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

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, psychiatric care services, Co-payment amounts, or charges in excess of the Reasonable and Customary charge. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the Schedule of Benefits.

OUTPATIENT—a Covered Person who receives services or supplies while not an Inpatient.

OUTPATIENT DIABETIC EDUCATION PROGRAM—means an Outpatient Diabetic Education Program provided by a Member Hospital of the Carrier, which has been recognized by the Pennsylvania Department of Health or the American Diabetes association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

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

PARTIAL HOSPITALIZATION—means medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient confinement.

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

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—means a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should 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.

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

- Certified Registered Nurse
- Nurse Midwife
- Chiropractor
- Optometrist

- Dentist
- Independent Clinical Laboratory
- Licensed audiologist
- Licensed speech-language pathologist
- Licensed teacher of the hearing impaired
- Physical Therapist
- Physician
- Podiatrist
- Psychologist

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

PSYCHIATRIC HOSPITAL—means a Facility Provider, approved by the Carrier, which for compensation from its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

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

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 for a Covered Service by a Provider 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 patient'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.

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

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

SEVERE SYSTEMIC PROTEIN ALLERGY—allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory

symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT—means a unit which is approved by the 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—means an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol or Drug Abuse, which:

- a. Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- b. Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- c. Is otherwise acceptable to the Carrier.

SURGERY—the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and all 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. **Radiation Therapy**
The 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.
- b. **Chemotherapy**
The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antimetetics, and other related biotech products.
- c. **Dialysis**
The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.
- d. **Cardiac Rehabilitation Therapy**
Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- e. **Physical Therapy**
Medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

f. **Respiratory Therapy**

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

g. **Occupational Therapy**

Medically prescribed treatment concerned with improving or restoring neuro-musculoskeletal 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 subscriber'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.

h. **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.

i. **Infusion Therapy**

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

j. **Pulmonary Rehabilitation Therapy**

Multidisciplinary treatment which combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

TOTAL DISABILITY—means that you, due to illness or injury, cannot perform any duty of your occupation or any occupation for which you are, or may be, suited by education, training and experience, and you are 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.

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