We would like to thank you for joining Keystone Health Plan’s (KHPE) East Point of Service program. Carrying a Keystone Point of Service ID card entitles you to access a large network of providers, our friendly service, our value-added benefits and our wellness programs.

To get the most from your KHPE Point of Service coverage, it’s important to become familiar with the benefits and services available to you. You’ll find this valuable information in your HMO Member Handbook that describes your referred benefits and Comprehensive Major Medical Booklet/Certificate that describes your self-referred benefits. Keep this Kit handy for future reference.

Your KHPE Point of Service Identification Card(s) (ID Card) will be mailed separately. Please check your card(s) carefully to be sure the information is accurate. You will need to use your card each time you visit your doctor, and when you are referred to or self-refer to a specialist, hospital or other health care provider.

If you need additional information, or have questions about your KHPE Point of Service coverage, please refer to the back of your ID Card for your Member Services Department telephone number. Our representatives will be happy to assist you with any questions.

It’s a pleasure to have you with us!

Renee J. Rhem
Director
Customer Service

*Referred benefits are underwritten by Keystone Health Plan East, Inc.; self-referred benefits are underwritten by QCC Insurance Company.
Table of Contents
Section Overview

Table of Contents .......................... Tab 1

How Your Plan Works .......................... Tab 2
This section contains helpful information to assist you in becoming familiar with your plan, including Frequently Asked Questions, Key Terms and important phone numbers you need to know.

Referred Benefits .......................... Tab 3
This section contains specialized information regarding your benefit package including the copayments, and/or coinsurance amounts for your medical coverage and any applicable ancillary benefits. This section will answer many of your questions regarding your benefits and Keystone’s procedures and services.

Self-Refereed Benefits ........................ Tab 4
This section provides information concerning your benefits when you choose to receive health care services without obtaining a referral from your Primary Care Physician.

Programs For Your Well Being .......................... Tab 5
This section provides information concerning your Keystone Healthy Lifestyles™ Portfolios. These programs offer reimbursements and discounts on activities designed to keep you in the best of health. Also included in this section are our Wellness Guidelines which provide you and your doctor with a starting point for discussion about your wellness decisions.

Forms .......................... Back Cover
This section provides you with ancillary benefit documents (when applicable), our Advance Directive Guidelines, claim forms, and other information.
How Your Plan Works
Section Overview

How Does Keystone Point-of-Service Work?

You Select Your Primary Care Physician (PCP)
from the Keystone Health Plan East Network.................................................. 2.2
Two Ways to Receive Benefits .......................................................................... 2.3
Your Advantages with Keystone Point-of-Service........................................ 2.3

Important Features of Your Group’s Program

What Does Your Identification Card Look Like? .................................................. 2.4
How to Access Emergency and Urgent Care....................................................... 2.4
Your Primary Care Physician (PCP) ................................................................. 2.5
How to Change Your PCP .............................................................................. 2.5
Services that Require Precertification/Preapproval ........................................ 2.6
Information You Need, Whenever You Need It .............................................. 2.6
Submitting a Claim Form for Self-Referred Care ........................................... 2.6

Frequently Asked Questions ............................................................................ 2.7

Key Terms ........................................................................................................... 2.10
How does Keystone Point-of-Service Work?

You Select Your Primary Care Physician (PCP) From the Keystone Health Plan East Network

When you require care, it’s your choice

Referred Care (In-Network)

Visit your Keystone PCP to provide or refer your care

Having care coordinated by your PCP ensures your highest level of coverage (Referred Care)

Referred Care is easy
• No deductible!
• Lower copayments!

Self-Referred Care (In-Network or Out-of-Network)

Seek care directly from any provider without a referral

Seeking care from any provider increases your out-of-pocket costs as deductible and coinsurance will apply (Self-Referred Care)

Self-Referred Care may require claims filing

As a Keystone Point-of-Service (POS) Member you can minimize your out-of-pocket costs by visiting your Keystone Health Plan East Primary Care Physician (PCP) who will coordinate your health care needs. However, if you would prefer to self-refer to a facility or physician who is in- or out-of-network, you have that choice. When you self-refer, you will be responsible for additional out-of-pocket expenses in comparison to referred care coordinated by your PCP. When you self-refer to an out-of-network provider, you are responsible for obtaining any required prior authorization.
Two Ways to Receive Benefits

1. Referred Coverage (In-Network only)

When you obtain a referral from your Keystone Health Plan East Primary Care Physician (PCP), you receive a higher level of coverage, and in most cases, there are no claim forms to file.

Please refer to your Keystone POS Member Handbook (Evidence of Coverage), in the Referred Benefits Tab of this Kit, for a description of the referred care benefits available to you when you obtain a referral from your Keystone PCP. Remember, Keystone Point-of-Service gives you choice. If you decide to receive medical care from Keystone participating providers and obtain a referral, your out-of-pocket costs will usually be lower.

2. Self-Referral Coverage (In-Network and Out-of-Network)

You have the option to use a provider or hospital of your choice without receiving a referral from your PCP.

The following are two ways you can access care without a referral:

   - If you choose to self-refer for covered services, and not obtain a referral from your PCP, they will be covered, subject to deductibles and coinsurance.

   - You will be responsible for the balance of the provider’s bill, if the charge is more than the covered expense.

A description of the benefits that are offered for care received on a self-referred basis is contained in your Booklet-Certificate in the Self-Referred Benefits Tab of this Kit. These benefits may not necessarily be the same as the referred care benefits.

Your Advantages with Keystone Point-of-Service

Participating Providers

Your PCP will be responsible for providing and coordinating your medical care, so you receive continuity in all aspects of treatment.

Health Care Whenever You Need It

Benefits are provided for emergency care, 24 hours a day, seven days a week, anytime, anywhere.

Unlimited Choice of Health Care Providers

With Keystone Point-of-Service, you have the comfort of knowing that you will have coverage when you use specialists or hospitals of your choice—with or without a referral!
Important Features of Your Group’s Program

What Does Your Identification Card Look Like?

Your Keystone Point-of-Service identification card contains important information for the doctors who treat you. Your new Keystone POS identification card should be carried with you at all times. You will receive a separate card for each enrolled family member. These identification cards are for you and your family’s use only. They may not be used by anyone else. When you or a family member seek medical services, be sure to present the card. Use it also when you receive emergency services.

The reverse side of your identification card provides information about medical services, especially for emergencies. Keystone Health Plan East has provided a toll-free number for use by hospitals for questions about your coverage.

If any of the information on your identification card is incorrect, you misplace a card or need additional identification cards, please call us at 1-800-ASK-BLUE (1-800-275-2583). We will issue a new identification card.

How to Access Emergency and Urgent Care

Emergency Care (Emergency or Life-Threatening Situation)

Instructions:
Go to the nearest emergency room or source of medical care. Please notify your PCP as soon as possible when care is provided by a physician other than your PCP. Examples of an Emergency situation: Onset of sudden, severe and persistent pain, or uncontrolled bleeding

Urgent Care (Possible Emergency/Unexpected Illness or Injury)

Instructions:
Call your PCP immediately for instruction. Examples of an Urgent Care situation: Severe vomiting or severe eye pain with redness

Note: If you call your PCP after hours, you may reach his/her answering service. The answering service will call your PCP, who will return your call as soon as possible. In these situations, please allow time for your PCP to return your call. Try to keep your phone free in the meantime. If your PCP does not call you back, please call Keystone Health Plan East at 1-800-ASK-BLUE (1-800-275-2583) for information. If you are out of the area, call 1-800-810-BLUE (2583) to find the nearest participating provider, then call 1-800-ASK-BLUE to obtain preauthorization.
Your Primary Care Physician (PCP)

When you enrolled in Keystone POS, you selected a PCP to be your personal doctor. The PCP is the coordinator of your health care and the medical professional qualified to treat you for your basic health care needs. If you need the services of a specialist (a dermatologist, cardiologist or surgeon, for example), diagnostic testing, hospitalization or any other service your PCP does not routinely provide, you will be referred by your PCP to an appropriate doctor or facility.

One of the features of Keystone POS is that each family member may have a different PCP. Each family member’s PCP will provide all basic health care for that individual and authorize any non-emergent medically necessary specialty care.

How to Change Your PCP

While a Keystone POS Member, you may elect to transfer to another PCP, due to a change of address, if a new doctor joins the Plan, or other reasons. You may change at any time during the year. If you change your PCP during the first part of the month, the change will become effective the first day of the following month. Please refer to your Keystone Member Handbook (Evidence of Coverage) in the Referred Benefits Tab for further details.

To change your primary care physician, you can call Customer Service at 1-800-ASK-BLUE (1-800-275-2583). You can also change your PCP by visiting www.ibxpress.com

The Keystone Health Plan East network of doctors is subject to change. If you would like to review a current list of our doctors, visit our web site at www.ibx.com or call 1-800-ASK-BLUE.
**Services That Require Precertification/Preapproval**

As a Keystone Point-of-Service Member, certain services require precertification or preapproval prior to receiving care. If you choose to self-refer, you are responsible to precertify certain care. Failure to obtain precertification for such services may result in a reduction of benefits. If your care is provided or referred by a Keystone Health Plan East Primary Care Physician, all necessary preapprovals will be obtained for you. Precertification and preapproval are important for you to understand. These processes are not the same as the process for receiving referrals from your PCP. Please refer to your Member Handbook and Booklet/Certificate for more information regarding precertification/preapproval and referrals.

*If you choose to self-refer to any provider, you are responsible for contacting our Patient Care Management Department at 1-800-ASK-BLUE (1-800-275-2583) to obtain necessary precertification. Failure to obtain precertification may result in a reduction of your benefits. Your Booklet-Certificate in the Self-Referred Benefits Tab outlines all services requiring precertification.*

**Information You Need, Whenever You Need It**

We welcome your questions, and encourage Members to call and receive information regarding benefits and/or coverage. Simply call Customer Service at 1-800-ASK-BLUE (1-800-275-2583), and one of our representatives will gladly address any questions or concerns.

To report suspected fraud/abuse, call 1-866-282-2707.

**Submitting a Claim Form for Self-Refered Care**

If you choose to self-refer for care, you may be required to submit your claim for consideration. **You need only to submit a claim for self-referred services.** To complete a form, simply follow the directions below:

1. Use the claim form included with your kit or call Keystone Health Plan East Customer Service at 1-800-ASK-BLUE (1-800-275-2583) to obtain a Keystone Point-of-Service claim form.
2. Attach your itemized bill(s) to the completed claim form.
3. Submit the claim form with the attached bills to the following address:
   
   Keystone Health Plan East
   Claims Processing Center
   P.O. Box 41574
   Philadelphia, PA 19101-1574

Any questions? Call Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at www.ibxpress.com.
Frequently Asked Questions

Q. What is the difference between referred care and self-referred care?

Referred care are those services that are provided by or coordinated through your Keystone Health Plan East PCP. When your care is referred, you will receive the highest level of benefits and no deductibles and low copayments.

Self-referred care are services you receive directly from an in-network (participating) or out-of-network (non-participating) provider without a referral. You will be subject to increased out of pocket costs, as deductibles and coinsurance will apply. If you self-refer to a non-participating provider, you will be responsible for the balance of the provider’s bill, if the charge is more than the covered expense. You may also need to file your claims for reimbursement.

Q. When I self-refer, who is responsible to precertify my benefits?

If you choose to self-refer to any provider, you are responsible for contacting us by calling 1-800-ASK-BLUE (1-800-275-2583) to obtain any necessary precertification. Failure to obtain precertification may result in a reduction of your benefits. Refer to your Booklet/Certificate for the services that require precertification.

Q. May I self-refer to a participating physician?

You have the option of self-referring to an in-network (participating) physician. By doing this, you are responsible for an annual deductible and coinsurance for covered services.

Q. Where will my PCP direct me when I need services such as X-rays?

PCPs provide Members with a referral and direct them to the designated location for their care. PCPs are required to choose one radiology, physical therapy, laboratory and podiatry site to which they send all of their Keystone Health Plan East Members. The PCP usually selects the same site he/she refers to for all such services. Before choosing your PCP, you may want to speak to your PCP regarding the sites he/she has chosen.

Q. Am I responsible for the difference between the amount billed and the covered expense if I self-refer?

In addition to your deductible and coinsurance, you will be responsible for the difference between the provider’s billed amount and the covered expense when you self-refer to a non-participating (out-of-network) provider for covered services (See “Key Terms” for a definition of covered expense). If you self-refer to a participating provider, you will be responsible for the deductible and coinsurance for covered services.
Q. When I self-refer, who is responsible for submitting the bill?

You may be required to submit a self-referred claim for consideration. A claim form is included in this Kit. Contact Customer Service for a Keystone Point-of-Service (POS) claim form. Complete the form, attach your itemized bill(s), and submit them to Claims Processing Center, P.O. Box 41574, Philadelphia, PA 19101-1574.

Q. How are benefits paid when I self-refer?

The payment differs depending on whether a Member self-refers to a participating or non-participating provider. For more details, please see the “Payment of Benefits” section of your self-referred care Booklet/Certificate.

**Self-referring to a Keystone Health Plan East participating provider.** The Member will be responsible for the deductible and coinsurance amounts.

**Self-referring to a nonparticipating provider.** The Member will be responsible for: 1) the deductible, 2) the coinsurance, and 3) the difference between the provider’s billed amount and the covered expense.

Q. What is applied to the deductible?

The amount applied to the deductible is based on the amount of covered expenses incurred during the benefits period for self-referred covered services.

Q. How do I access a Provider for Mental Health or Substance Abuse treatment services?

Coverage of Mental Health and Substance Abuse benefits depends on the terms and conditions of your group health plan. If your group health plan includes Mental Health and Substance Abuse benefits, you might be covered for certain treatment/services.

If you require outpatient or inpatient Mental Health or Substance Abuse services, a written referral is not necessary from your Primary Care Physician. The behavioral health management company that administers your Keystone Health Plan East mental health and substance abuse benefits can be reached by calling Member Services at **1-800-ASK-BLUE** (1-800-275-2583).

Please be advised that your group may have contracted with an independent behavioral health vendor/organization, other than Keystone Health Plan East, to coordinate and process claims for mental health/substance abuse services/treatments. If this is the case, your Keystone Health Plan East health benefits plan does not provide coverage for your mental health and substance abuse benefits. If you have questions about the behavioral health management company that administers your benefits plan, please contact your Employer/Plan Administrator.

See your Member handbook for more information about requirements for pre-certification and other requirements that may apply to certain requests for Mental Health and Substance Abuse services/treatments.
Q. If I self-refer myself to a Keystone Health Plan East surgeon, how will the hospital charges be covered?

All covered services associated with a self-referred admission will be paid at a self-referred benefit level, as outlined in the Self-Referred Benefits Tab. Be sure to contact the Patient Care Management Department at 1-800-ASK-BLUE (1-800-275-2583) to obtain the necessary pre-certification prior to any self-referred admission.

Q. How do I access care when I am traveling outside the service area?

Whether you are traveling to another state or another country, Keystone Health Plan East has you covered through the BlueCard® and BlueCard Worldwide® programs. In an emergency, you should go to the nearest hospital. For urgent care call the BlueCard Access line at 1-800-810-BLUE (2583) or collect at 1-804-673-1177 for the names of Blue Cross®/Blue Shield® traditional providers (BlueCard® Providers) in the area you are traveling. You can call BlueCard Access® 24 hours a day, seven days a week, from anywhere in the world. You will also need to obtain precertification for nonemergent services outside Keystone’s network by calling Keystone Health Plan East at 1-800-ASK-BLUE (1-800-275-2583) before receiving care.

Always carry your most current identification card when you travel. If you have any questions about your coverage, call Customer Service 1-800-ASK-BLUE (1-800-275-2583).
Key Terms

Coinsurance
A percentage of the covered expenses which must be paid by the Member when self-referring.  
Note: The Member is responsible for the difference between the amount billed and the covered expense under the self-referred option when utilizing a non-participating provider.

Contracted Fee
Refers to the amount negotiated by Keystone Health Plan East and a participating provider as payment for services rendered.

Copayment
A specific amount that a Member must pay out-of-pocket for a covered service under the referred option.

Covered Expense
Refers to the basis by which a Member’s deductibles, coinsurance, benefit maximums and benefits will be calculated under the self-referred option.

Deductible
A flat dollar amount the Member or family must incur in a benefit period before any benefit payments are made.

Emergency Care
The initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury.

Health Maintenance Organization “HMO”
A Health Maintenance Organization (HMO) provides a complete range of medical benefits through a selected group of doctors and hospitals. One doctor, the Primary Care Physician (family doctor or pediatrician) coordinates a Member’s overall medical needs. The Member’s Primary Care Physician refers all specialty care needs.

In-Network
Refers to when a Member receives services from a participating provider.

Out-of-Network
Refers to when a Member receives services from a provider or facility who does not participate with the health plan.

Out-of-Pocket Expenses/Costs
A specific dollar amount or expenses incurred by a Member for covered services in a benefit period.

Participating Provider
A facility or professional provider (doctor, hospital, etc.) contracted with Keystone Health Plan East to accept a rate of reimbursement determined by their contract with Keystone Health Plan East, for services rendered to Keystone Health Plan East Members.

Point-of-Service “POS”
A health care option that allows Members to choose to obtain covered services through referred care or self-referred care.
Precertification/Preapproval
The process of obtaining certification or approval from a Member’s health plan for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Under the referred option, the PCP seeks prior authorization from the health plan for the Member. Under the self-referred option, the Member is responsible for obtaining precertification/preapproval.

Primary Care Physician (PCP)
A general practitioner, family practitioner, internist or pediatrician who acts as a Member’s personal physician and coordinates that Member’s health care.

Referral
Written documentation from the Member’s PCP authorizing care at a participating or non-participating specialist/provider for covered services.

Referred Care
Care subject to PCP coordination and/or other terms stated in the Member Handbook.

Self-Referred Care
Care a Member seeks directly from a provider which is subject to the terms stated in the self-referred care Booklet/Certificate.

Urgent Care
Care which a Member seeks as a result of an unforeseen illness, injury or condition in non-routine or non-emergency situations.
Referred Benefits
Schedule(s), Rider(s) and Handbook/ Subscriber Agreement

Changes to your Cost Sharing – Amendment .................................3.1-2
COPAYMENT SCHEDULE ......................................................3.1-4
DENTAL RIDER .................................................................3.1-13
VISION RIDER .................................................................3.1-19
DOMESTIC PARTNERS RIDER ...............................................3.1-20
AUTISM MANDATE .............................................................3.1-21
BENEFITS RIDER ..............................................................3.1-27
BENEFITS RIDER ..............................................................3.1-31
BENEFITS RIDER ..............................................................3.1-34
BENEFIT RIDER .................................................................3.1-35
HEALTH CARE REFORM AMENDMENT ........................................3.1-43
HANDBOOK ......................................................................3.2-1
Changes to Your Cost Sharing – Letter Amendment

Annual and Lifetime Dollar Maximums:

All lifetime and annual dollar benefit maximums for essential benefits have been removed.

100% Preventive Care:

Health benefit plans now provide 100% coverage for certain designated Preventive Care services. There will be no cost sharing (copayments, coinsurance, deductibles) for the following Preventive Care Services if provided by a Participating Provider:

1. Evidence-based items/services with a rating of “A” or “B” in the current recommendations of the U.S. Preventative Services Task Force.
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
4. With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.
SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS

You are entitled to benefits for the Covered Services described in your Handbook, subject to any Coinsurance, Copayment or Limitations described below.

If the Participating Provider’s usual fee for a Covered Service is less than the Coinsurance or Copayment shown in this Schedule, you are only responsible to pay the Participating Provider’s usual fee. The Participating Provider is required to remit any Coinsurance or Copayment overpayment directly to you. If you have any questions, contact Member Services at the phone number on your ID Card.

Your Primary Care Physician or Specialist must obtain Preapproval from the HMO to confirm the HMO’s coverage for certain Covered Services. If your Primary Care Physician or Specialist provides a Covered Service or Referral without obtaining the HMO’s Preapproval, you are not responsible for payment for that Covered Service. The Covered Services that require Preapproval appears in the COVERED SERVICES REQUIRING PREAPPROVAL list you received with your Handbook.

### PRIMARY AND PREVENTIVE CARE COVERED SERVICES COPAYMENTS & LIMITATIONS

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits to Your PCP (Includes Home Visits and Outpatient Consultations)</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Office Visits to a Specialist</td>
<td>$30 per visit</td>
</tr>
<tr>
<td>Pediatric Preventive Care</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Pediatric Immunizations (Birth to age 21)</td>
<td>$0</td>
</tr>
<tr>
<td>Adult Preventive Care</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Routine Gynecological Examination (Includes Pap Smear one (1) per calendar year, all ages)</td>
<td>$15 per visit</td>
</tr>
<tr>
<td>Mammograms</td>
<td>$0</td>
</tr>
</tbody>
</table>
### INPATIENT COVERED SERVICES COPAYMENTS & LIMITATIONS

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL SERVICES</strong></td>
<td>$100 per day up to five (5) days, with $500 maximum per admission</td>
</tr>
<tr>
<td><strong>MEDICAL CARE</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>SKILLED NURSING CARE FACILITY</strong></td>
<td>$50 per day up to five (5) days, with $250 maximum per admission</td>
</tr>
</tbody>
</table>

Maximum of one hundred twenty (120) Inpatient days per calendar year.
INPATIENT/OUTPATIENT COVERED SERVICES COPAYMENTS & LIMITATIONS

BLOOD $0

HOSPICE SERVICES

Inpatient Hospice Services $0

Outpatient Hospice Services

Professional Service $0
Facility Service for Respite Care $0

Respite Care is provided for a maximum of seven (7) days every six (6) months.

MATERNITY/OBSTETRICAL –
GYNECOLOGICAL/FAMILY SERVICES

Non-Routine Maternity/Obstetrical Care

Professional Service $15 first visit only
Facility Services* $100 per day up to five (5) days, with $500 maximum per admission

Elective Abortions

Professional Service $15
Facility Services $50 per Outpatient surgical procedure performed

Newborn Care $0

Artificial Insemination $15 per visit
MENTAL HEALTH CARE

Inpatient Mental Health Care Admissions* $100 per day up to five (5) days, with $500 maximum per admission

Thirty (30) Inpatient days per calendar year

Outpatient Mental Health Care Visits/Sessions $30 per visit/session

Twenty (20) outpatient visits/sessions per calendar year

Up to thirty (30) Inpatient days may be exchanged for up to sixty (60) Outpatient visits/sessions per calendar year.

SERIOUS MENTAL ILLNESS HEALTH CARE

Inpatient Serious Mental Illness Health Care Admissions* $100 per day up to five (5) days, with $500 maximum per admission

Thirty (30) inpatient days per calendar year

Outpatient Serious Mental Illness Health Care Visits/Sessions $30 per visit/session

Sixty (60) outpatient visits/sessions per calendar year

Each available Inpatient day may be exchanged for two (2) additional Outpatient visits/sessions per calendar year.
INPATIENT/OUTPATIENT COVERED SERVICES COPAYMENTS & LIMITATIONS
(Continued)

SUBSTANCE ABUSE TREATMENT

Inpatient Substance Abuse Admissions*  
$100 per day up to five (5) days, with $500 maximum per admission

Thirty (30) Inpatient days per calendar year in a Department of Health licensed substance abuse treatment program in an acute care Hospital or a Substance Abuse Treatment Facility.

Lifetime Benefit Maximum: ninety (90) days

Up to (30) of the sixty (60) available Outpatient Substance Abuse visits/sessions may be exchanged, based on Medical Necessity, for up to fifteen (15) additional Inpatient days per calendar year. These additional inpatient days are considered a part of the Inpatient Lifetime Maximum days.

Outpatient Substance Abuse Treatment Visits/Sessions (including Outpatient Detoxification)  
$30 per visit/session

Sixty (60) outpatient visits/sessions per year

Lifetime Benefit Maximum of one hundred twenty (120) visits/sessions

Detoxification Services

Inpatient Detoxification Services Admissions*  
$100 per day up to five (5) days, with $500 maximum per admission

Inpatient treatment limited to seven (7) days per admission

Lifetime Benefit Maximum of four (4) admissions
SURGICAL SERVICES

Outpatient Facility Charges  $50 per Outpatient surgical procedure performed

Outpatient Anesthesia  $0

Voluntary Second Surgical Opinion  $30 per opinion

If more than one (1) surgical procedure is performed by the same Professional Provider during the same operative session, the HMO will pay 100% of the contracted fee schedule amount, less any required Member Copayments, for the highest paying procedure and 50% of the contracted fee schedule amount for each additional procedure.

TRANSPLANT SERVICES  Applicable inpatient or outpatient facility or professional provider Coinsurance or Copayments will apply.
<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBULANCE</td>
<td>$0</td>
</tr>
<tr>
<td>DIABETIC EDUCATION PROGRAM</td>
<td>$0</td>
</tr>
</tbody>
</table>

Coinsurance, Copayments, Deductibles and Maximum amounts do not apply to this benefit.

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIABETIC EQUIPMENT AND SUPPLIES</td>
<td>30% of the contracted fee schedule amount for a Durable Medical Equipment Provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSTIC SERVICES</td>
<td></td>
</tr>
<tr>
<td>Routine Diagnostic Services</td>
<td>$30 per date of service</td>
</tr>
<tr>
<td>Non-Routine Diagnostic Services</td>
<td>$60 per date of service</td>
</tr>
<tr>
<td>(including MRI/MRA, CT scans, PET scans)</td>
<td></td>
</tr>
<tr>
<td>Laboratory and Pathology Tests</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURABLE MEDICAL EQUIPMENT</td>
<td>30% of the contracted fee schedule amount for a Durable Medical Equipment Provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY CARE - FACILITY</td>
<td>$100 per visit</td>
</tr>
<tr>
<td>HOME HEALTH CARE</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>INJECTABLE MEDICATIONS</td>
<td></td>
</tr>
<tr>
<td>Biotech/Specialty Injectables</td>
<td>$75</td>
</tr>
<tr>
<td>Standard Injectables</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSULIN AND ORAL AGENTS</td>
<td>$10/$15</td>
</tr>
</tbody>
</table>

If this plan does not provide separate coverage for prescription drugs, insulin and oral agents are covered less the applicable Copayment per prescription order.
MEDICAL FOODS AND NUTRITIONAL FORMULAS  $0

PRIVATE DUTY NURSING SERVICES  10% of the Participating Provider’s contracted fee schedule amount

Three hundred sixty (360) hours per calendar year

PROSTHETIC DEVICES  30% of the Participating Provider’s contracted fee schedule amount per device

Breast Prostheses

Internal and external breast prostheses include:

1. Four (4) post mastectomy bras per calendar year;
2. Silicone breast prostheses, with a life expectancy of a minimum of two (2) years; and
3. Fabric, foam, or fiber-filled breast prostheses, with a life expectancy of a minimum of six (6) months.

SPINAL MANIPULATION SERVICES  $30 per visit

Twenty (20) visits per calendar year

THERAPY SERVICES

Cardiac Rehabilitation Therapy  $30 per visit

Thirty-six (36) sessions per calendar year

Chemotherapy  $0

Dialysis  $0

Infusion Therapy  $0

Orthoptic/Pleoptic Therapy  $30 per visit

Lifetime Maximum: eight (8) sessions
Pulmonary Rehabilitation Therapy $30 per visit
Thirty-six (36) sessions per calendar year

Physical Therapy/Occupational Therapy $30 per visit
Thirty (30) visits per calendar year

Radiation Therapy $0

Speech Therapy $30 per visit
Twenty (20) visits per calendar year

LIMITING AGE FOR DEPENDENTS
Children under age 19
Full-time students under age 23

Dependent Coverage will terminate at the end of the month in which the child attains the Limiting Age.

ANNUAL COPAYMENT MAXIMUMS

Member Copayments as listed on this schedule are limited to $1,500 per Member and $3,000 per family per calendar year. To be eligible for reimbursement under this provision, contact Member Services. You will be asked to supply information in order to demonstrate that the Annual Copayment Maximum amount has been reached.

This maximum includes Copayments required under the Vision Rider, if made a part of this Plan.

This maximum does not include Coinsurance amounts listed in this Schedule or any Copayment or Coinsurance amounts required under a Prescription Drug Rider, if made a part of this Plan.

*The inpatient Copayment will be waived for readmissions within ninety (90) days of discharge for any diagnosis.

PA FD 624 MHSC  P575, P587, P599
ED. 11/04
VALUE DENTAL BENEFITS

Dental benefits are provided as shown in the SUMMARY OF BENEFITS and in the SCHEDULE OF COPAYMENTS & LIMITATIONS.

SUMMARY OF BENEFITS

OUTPATIENT BENEFITS

* You and your eligible Dependents are entitled to the Dental Covered Services shown in the SCHEDULE OF COPAYMENTS & LIMITATIONS. These Dental Covered Services are eligible provided they are performed directly by a Primary Dentist. Dental Covered Services are subject to the provisions listed in this SUMMARY OF BENEFITS, the exclusions contained in the list of DENTAL EXCLUSIONS and to the Copayments and Limitations listed in the SCHEDULE OF COPAYMENTS & LIMITATIONS.

HOW TO ACCESS DENTAL CARE

In order to access dental care for you and your eligible Dependents, you need to know the following requirements:

Selection of a Primary Dentist

Prior to the time your coverage becomes effective, you need to choose the Primary Dentist from whom you and your Dependents will receive Dental Covered Services.

Changing a Primary Dentist

1. If you and your eligible Dependents wish to transfer to a different Primary Dentist, a request may be submitted in writing or by telephone to the Member Services Department. If notification to change a Primary Dentist is received prior to the fifteenth day of the month, the change will become effective the first day of the next month. Requests received after the fifteenth will become effective the first day of the month immediately following the next month.

2. A Primary Dentist may request in writing that care for you and your eligible Dependents be transferred to another Primary Dentist. However, a Primary Dentist may not request a transfer because of the physical condition of a patient or the amount of Dental Covered Services required by a patient.
3. Transfer to another Primary Dentist may be required if the Member-Primary Dentist relationship is unsatisfactory.

4. If the Primary Dentist terminates his relationship with the HMO, you and your eligible Dependents must select another Primary Dentist. Member Services will assist you in this selection process.
**IMPORTANT DEFINITIONS**

For the purpose of understanding the benefits under your dental program, the terms below have the following meaning:

* **DENTAL COVERED SERVICES** – professional services of Dentists and auxiliary personnel as set forth in the SCHEDULE OF COPAYMENTS & LIMITATIONS and except as excluded under the DENTAL EXCLUSIONS section.

* **DENTALLY NECESSARY** – services or supplies provided by a Primary Dentist, except for Dental Emergency Care, that are:
  
  A. appropriate for the symptoms and diagnosis or treatment of the Member’s condition, illness, disease or injury;
  
  B. provided for the diagnosis, or the direct care and treatment of the patient’s condition, illness, disease or injury;
  
  C. in accordance with accepted standards of American dental practice;
  
  D. not primarily for the convenience of the patient or the provider.

* **DENTIST** – a licensed Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Medicine, or Doctor of Osteopathy.

* **PRIMARY DENTAL OFFICE** – the dental office maintained by the Primary Dentist.

* **PRIMARY DENTIST**. – a person licensed to practice dentistry who is under contract to provide all primary Dental Covered Services.
DENTAL EXCLUSIONS

The following are excluded from coverage under your dental benefits:

Except as specifically provided in the SCHEDULE OF COPAYMENTS & LIMITATIONS, no benefits will be provided for services, supplies, or charges:

1. which are not prescribed or performed by or under the direct supervision of the Primary Dentist;

2. which are not Dentally Necessary as defined in the IMPORTANT DEFINITIONS section;

3. which are cosmetic in nature, including but not limited to, charges for personalization or characterization of prosthetic appliances;

4. which do not meet accepted standards of American dental practice;

5. for labial veneers and laminates when done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered;

6. for duplicate devices, appliances, and services;

7. for temporary devices, appliances, and services that are integral to the overall procedure;

8. related to the diagnosis and treatment of temporomandibular joint dysfunctions;

9. for implantology and related services;

10. performed in a facility by a Primary Dentist who is compensated by facility for similar Dental Covered Services performed for patients;

11. to alter vertical dimension or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth;

12. for local anesthesia when billed separately by a Primary Dentist;

13. for gold foil restorations;

14. if you have a previous unresolved Copayment balance that has been outstanding for sixty (60) or more days, unless special payment arrangements have been made with the Primary Dentist Office;

15. for prescription medications or nitrous oxide;
16. for general anesthesia or IV sedation;

17. in a Hospital unless Dentally Necessary;

18. which are necessary due to a lack of patient cooperation or failure of the patient to follow a professionally prescribed Plan Of Treatment;

19. for periodontal splinting and any related procedures;

20. for treatment of congenital malformations, including but not limited to, cleft palate, anodontia and mandibular prognathism;

21. for dental prosthetic devices including dentures, bridges, crowns, inlays and onlays and the fitting thereof;

22. for replacement of a lost or stolen prosthetic device (such as a denture) or the replacement or repair of orthodontic braces;

23. for treatment of orthodontic conditions;

24. for orthognathic surgery to cover non-traumatic jaw deformity;

25. other than those specifically provided in the SCHEDULE OF COPAYMENTS & LIMITATIONS.
### SCHEDULE OF COPAYMENTS & LIMITATIONS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment/Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DENTAL VISITS</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Office Visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Missed Dental Office Visit</td>
<td>$15 per half hour appointment without 24 hour notice</td>
</tr>
</tbody>
</table>

The following services are covered subject to the $5 office visit Copayment when provided by the Primary Dentist.

### DENTAL PREVENTIVE

- **Oral Examination & Diagnosis**: once every six (6) months
- **Prophylaxis (teeth cleaning)**: once every six (6) months
- **Oral Hygiene Instruction**
- **Topical Fluoride Application**: limited to children up to age 19, once every six (6) months
VISION CARE BENEFITS

Vision Examination

Each Member may have one (1) routine eye exam and refraction every two (2) calendar years. These services must be provided by a Participating Provider. A list of Participating Providers is available through the Member Services.

Check the Specialist Office Visit Copay in the Schedule of Copayments & Limitations to determine if a Copayment applies to this service.

Prescription Lenses And Frames From a Participating Provider

Each Member is entitled to the following benefits for vision frames and prescription lenses once every two (2) calendar years when provided by a Participating Provider:

(1) One (1) pair of frames from a select group of frames; and

(2) One (1) set of eyeglass lenses that may be plastic or glass lenses, single, bifocal, or trifocal lenses, lenticular lenses, and/or oversized lenses.

Benefits are provided for prescription contact lenses in lieu of eyeglasses for up to $35 every two (2) calendar years.

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

Each Member is entitled to a reimbursement for the cost of corrective lenses, including prescription contact lenses, and eyeglass frames. The reimbursement amount is stated below and will be paid when a properly receipted bill is submitted. Instructions for reimbursement may be obtained from Member Services.

Reimbursement Amount $35 every two (2) calendar years
This Rider modifies your Evidence of Coverage (Handbook) to include the following definition under IMPORTANT DEFINITIONS:

**DOMESTIC PARTNER (DOMESTIC PARTNERSHIP)** - an individual of a Domestic Partnership consisting of two people each of whom:

A. is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;

B. is not related to the other partner by adoption or blood;

C. is the sole Domestic Partner of the other partner, with whom he/she has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six (6) months;

D. agrees to be jointly responsible for the basic living expenses and welfare of the other partner;

E. meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and

F. demonstrates financial interdependence by submission of proof of three (3) or more of the following documents:

1. a Domestic Partnership agreement;
2. a joint mortgage or lease;
3. a designation of one of the partners as beneficiary in the other partner's will;
4. a durable property and health care powers of attorney;
5. a joint title to an automobile, or joint bank account or credit account; or
6. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

The HMO reserves the right to request documentation of any of the foregoing prior to continuing coverage for the Domestic Partner.
AUTISM SPECTRUM DISORDERS
This notification modifies your Handbook with the following language:

HOW TO USE THE SYSTEM
The section which describes how to use the system or how the plan works is revised as follows:
Under the "Prescription Drugs" sub-section, the introductory paragraph is expanded to include a description for access to coverage of Prescription Drugs used in the treatment of Autism Spectrum Disorders, when you are not an Inpatient.

DESCRIPTION OF COVERED SERVICES
The Outpatient Services sub-section is expanded to include the following:

Autism Spectrum Disorders
Benefits are provided for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for members under twenty-one (21) years of age when provided or Referred by the Primary Care Physician for the development of an ASD Treatment Plan.
Benefits are subject to the Annual Benefit Maximum listed in your Schedule of Cost Sharing and Limitations. All Medically Necessary care available for the treatment of ASD will be accrued against the Annual Benefit Maximum.
Treatment of Autism Spectrum Disorders must be:
a. prescribed, ordered or provided by a Participating Professional Provider, including your Primary Care Physician, Referred Specialist, licensed physician assistant, licensed psychologist, licensed Clinical Social Worker or Certified Registered Nurse practitioner;
b. provided by an Autism Service Provider, including a Behavior Specialist; or
c. provided by a person, entity or group that works under the direction of an Autism Service Provider.

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

- **Applied Behavioral Analysis** – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

- **Pharmacy Care** - The following when Prescribed and/or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner who is a Participating Professional Provider:
  (1) medications; and
  (2) any assessment, evaluation or test to determine the need or effectiveness of such medications.
If this plan provides benefits for outpatient prescription drugs through the program or under a Freestanding Prescription Drug agreement issued under this plan, the ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable under the Prescription Drug rider.

If this plan does not provide coverage for outpatient prescription drugs through the program or under a Freestanding Prescription Drug agreement issued under this plan, ASD medications may be purchased at a retail pharmacy and are covered at the cost sharing stated in your Schedule of Cost Sharing and Limitations subject to the ASD Annual Benefit Maximum. In order to receive reimbursement, you must submit a completed claim form to the address listed on the form. You can access a claim form at the website listed on the back of your ID Card or you can call Customer Service at the phone number also listed on the back of your ID Card to have one mailed to you.

- **Psychiatric Care** – Direct or consultative services provided by a physician specializing in psychiatry who is a Participating Professional Provider.

- **Psychological Care** – Direct or consultative services provided by a psychologist who is a Participating Professional Provider.

- **Rehabilitative Care** – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

- **Therapeutic Care** – Services provided by a speech language pathologist, occupational therapist or physical therapist who is a Participating Professional Provider.

**ASD Treatment Plan**

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

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

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a member shall be entitled to file an appeal. The appeal process will: 1) provide internal review followed by independent external review; and, 2) have levels, expedited and standard appeal time frames, and other terms established by the program consistent with applicable Pennsylvania and federal law. Appeal filing procedures will be described in notices denying any Autism Spectrum Disorders benefits. Full appeal process descriptions will be provided after a new appeal is initiated and can also be obtained at any time by contacting Customer Service.
EXCLUSIONS – WHAT IS NOT COVERED

1. The following exclusion is added:
   With respect to Autism Spectrum Disorders:
   (a) Services for ASD that exceed the Annual Benefit Maximum shown on Schedule of Cost Sharing and Limitations.
   (b) Diagnosis and treatment of Autism Spectrum Disorders that are provided through a school as part of an individualized education program.
   (c) Diagnosis and treatment of Autism Spectrum Disorders that are not included in the ASD Treatment Plan.

2. The exclusion relating to Mental Health Services is replaced by the following:
   Any care that extends beyond traditional medical management for Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, mental retardation or Autism Spectrum Disorders; or treatment or care to effect environmental or social change.

3. The exclusion relating to Therapy Services is revised to replace the item pertaining to day limits with the following:
   Any therapy service provided for:
   (2) additional therapy beyond the plan’s day limits, if any, shown on the Schedule of Cost Sharing & Limitations. This does not include services provided for Autism Spectrum Disorders which have no visit limits;

4. The exclusion relating to Designated Providers is replaced by the following:
   The following outpatient services that are not performed by your Primary Care Physician’s Designated Provider, when required under the Plan, unless Preapproved by the program: (a) rehabilitation Therapy Services (other than Speech Therapy and services for Autism Spectrum Disorders); (b) certain podiatry services if you are age nineteen (19) or older; and (c) diagnostic radiology services if you are age five (5) or older;

5. The exclusion relating to Prescription Drugs is replaced with the following:
   With regard to drugs and medications:
   (a) The following, except if covered by a Prescription Drug Rider:
       (1) Outpatient Prescription Drugs
       (2) Contraceptive drugs and devices;
   (b) Medications that may be dispensed without a doctor's prescription;
   This exclusion does not apply for coverage of Prescription Drugs that may be covered under your plan such as oral agents, insulin, and/or drugs used in the treatment of ASD, when applicable, if the member does not have coverage through a Prescription Drug Rider.
IMPORTANT DEFINITIONS

1. The following definitions are added:

- **ANNUAL BENEFIT MAXIMUM** - the maximum amount of benefits provided to a member in each calendar year. This amount is shown in the Schedule Of Cost Sharing & Limitations. The annual benefit maximum does not include any Copayments, Coinsurance and/or Deductibles paid by the member.

- **AUTISM SERVICE PROVIDER** - a person, entity or group providing treatment of Autism Spectrum Disorders, pursuant to an ASD Treatment Plan, that is either: (i) licensed or certified in this Commonwealth, or (ii) enrolled in the Commonwealth's medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law. An Autism Service Provider shall include a Behavior Specialist.

- **AUTISM SPECTRUM DISORDERS (ASD)** - means any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.

- **AUTISM SPECTRUM DISORDERS TREATMENT PLAN (ASD TREATMENT PLAN)** – a plan for the treatment of Autism Spectrum Disorders developed by a licensed physician or licensed psychologist who is a Participating Profession Provider pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

- **BEHAVIOR SPECIALIST** - means an individual who designs, implements or evaluates a behavior modification intervention component of an ASD Treatment Plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

2. The definition of "Behavioral Health/Substance Abuse Provider" listed under the definition of PARTICIPATING PROVIDER is expanded to add the following sentence:

Behavior Specialists are contracted to provide Covered Services for treatment of Autism Spectrum Disorders only.

3. The definition of PROFESSIONAL PROVIDER is replaced by the following:

- **PROFESSIONAL PROVIDER** - a person or practitioner who is certified, registered or who is licensed and performing services within the scope of such licensure. The Professional Providers are:
  - Autism Service Provider
  - Audiologist
  - Optometrist
  - Certified Registered Nurse
  - Registered Dietitian
  - Certified Nurse Midwife
  - Chiropractor
  - Dentist
  - Licensed Clinical Social Worker
  - Physical Therapist
  - Physician
  - Podiatrist
  - Psychologist
  - Speech-language Pathologist
  - Teacher of the hearing impaired
  - Independent Clinical Laboratory
  - Behavior Specialist
4. The definition of MENTAL ILLNESS is replaced by the following:

- MENTAL ILLNESS - any of various conditions categorized as mental disorders by the most recent edition of the International Classification of Diseases (ICD), wherein mental treatment is provided by a qualified Behavioral Health Provider. For purposes of this Handbook, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness and Autism Spectrum Disorders. The benefit limits for these services are separate and not cumulative.

**SCHEDULE OF COST SHARING AND LIMITATIONS**

1. The following sub-section is added. If your plan includes self-referred benefits, any amounts accumulated toward the Annual Benefit Maximum are combined with your referred benefits.

**AUTISM SPECTRUM DISORDERS (ASD)**

Covered Services (Other than ASD Prescription Drugs)

Same cost sharing as any other Covered Service within the applicable medical service category (e.g. Specialist, Hospital Services, Therapy Services, etc.)

ASD Annual Benefit Maximum: $36,000

Amounts accumulated toward the Annual Benefit Maximum for Autism Spectrum Disorders are determined by all benefits paid for this condition. Copayments, Coinsurance, and/or Deductibles paid by the member are not added to the Annual Benefit Maximum.

Visit limits do not apply to services provided for this condition.

2. The current sub-section for INSULIN AND ORAL AGENTS is replaced with the following:

**LIMITED PHARMACY** (applicable to coverage of Diabetes and ASD only, when covered under your plan):

**Insulin And Oral Agents**

- **Generic/Brand Name Drug Cost-sharing amount:** $10/15

**ASD Prescription Drugs, Oral Agent**

- 30% of retail pharmacy price
- Deductible not applicable
- Amounts paid in benefits will be applied to the $36,000 ASD Annual Benefit Maximum.
Pharmacy Limitations:

1. This benefit does not include insulin and oral agents or ASD drugs available under a Prescription Drug Rider or a Freestanding Prescription Drug agreement issued under the plan.

2. A pharmacy need not dispense a Prescription Order which, in the Pharmacist's professional judgment, should not be filled, without first consulting with the prescribing physician.

3. The quantity of a Prescription Drug, for purposes of cost-sharing, dispensed from a pharmacy pursuant to a Prescription Order or Refill is limited to thirty (30) days. That is, you will be responsible for the cost for each thirty (30) day supply of insulin or oral agents or your ASD drug.

4. Prescription Refills will not be provided beyond six (6) months from the most recent dispensing date.

5. Prescription Refills will be dispensed only if 75% of the previously dispensed quantity has been consumed based on the dosage Prescribed.

6. You will pay to the pharmacy one hundred percent (100%) of the cost for the insulin or oral agent dispensed or ASD drug. A claim for reimbursement must be submitted to the program. You can access a claim form at the website listed on the back of your ID Card or you can call Customer Service at the phone number also listed on the back of your ID Card to have one mailed to you.

All provisions of the benefit description material not changed by this notification still apply.
UTILIZATION MANAGEMENT RIDER

INFORMATION ABOUT OUR UTILIZATION REVIEW PROCESS AND CRITERIA

Utilization Review Process:

Two conditions of the HMO’s and its affiliates’ benefit plan are that in order for a health care service to be covered or payable, the service must be (1) eligible for coverage under the benefit plan and (2) Medically Necessary. To assist the HMO in making coverage determinations for certain requested health care services, the HMO uses established HMO medical policies and medical guidelines based on clinically credible evidence to determine the Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Member’s benefit plan is called utilization review.

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

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

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

Should a procedure be denied for coverage based on lack of Medical Necessity a letter is sent to the requesting Provider and Member in accordance with applicable law.

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

**Pre-Certification or Preapproval:**

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

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

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

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

- **hysterectomy**
- **nasal surgery procedures**
- **bariatric surgery**
- **potentially cosmetic or Experimental/Investigative Services**

**Concurrent Review:**

Concurrent review may be performed while services are being performed. This may occur during an inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. When performed, the review assesses the level of care provided to the Member and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all inpatient stays are reviewed concurrently. Concurrent review is generally not performed where an inpatient facility is paid based on a per case or diagnosis-related basis, or where an agreement with the facility does not require such review.

**Retrospective Review:**

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the HMO not being notified of a Member’s inpatient admission until after discharge or where medical charts are unavailable at the time of a required concurrent review. Certain services are only reviewed on a retrospective basis.
Prenotification:

In addition to the standard utilization reviews outlined above, the HMO also may determine coverage of certain procedures and other Benefits available to Members through Prenotification, as required by the Members' benefit plan, and discharge planning. Prenotification is advance notification to the HMO of an inpatient admission or outpatient service where no Medical Necessity review (Pre-Certification or Preapproval) is required, such as maternity admissions/deliveries. Prenotification is primarily used to identify Members for concurrent review needs, to ascertain discharge planning needs proactively, and to identify who may benefit from case management programs.

Discharge Planning:

Discharge planning is performed during an inpatient admission and is used to identify and coordinate a Member’s needs and benefit plan coverage following the inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves the HMO’s authorization of post-Hospital Covered Services and identifying and referring Members to disease management or case management benefits.

Selective Medical Review:

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

CLINICAL CRITERIA, GUIDELINES AND RESOURCES:

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

Clinical Decision Support Criteria:

Clinical decision support criteria are an externally validated and computer-based system used to assist the HMO in determining Medical Necessity. These evidence-based, clinical decision support criteria are nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist the HMO’s clinical staff in evaluating the Medical Necessity and appropriateness of coverage based on a Member’s specific clinical needs. Clinical decision support criteria help promote consistency in the HMO’s plan determinations for similar medical issues and requests, and reduce practice variation among the HMO’s clinical staff to minimize subjective decision-making.

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

- Some elective surgeries--settings for inpatient and outpatient procedures (e.g. hysterectomy and sinus surgery)
- Inpatient Hospital Services
Inpatient rehabilitation care
Home Health Care
Durable Medical Equipment (DME)
Skilled Nursing Facility Services

Centers for Medicare and Medicaid Services (CMS) Guidelines:

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

The HMO’s Medical Policies:

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

The HMO’s medical polices may be applied for Covered Services including, but not limited to the following:

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

The HMO’s Internally Developed Guidelines:

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

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA:

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

Utilization Review and Criteria for Behavioral Health Services:

Utilization Review activities for behavioral health services (mental health and Substance Abuse services) have been delegated by the HMO to its contracted behavioral health management company which administers the behavioral health Benefits for the majority of the HMO’s Members.
SERVICES AND SUPPLIES REQUIRING PREAPPROVAL OR PRENOTIFICATION RIDER

For the services listed below, the treating physician in the HMO’s network is required to obtain Preapproval from the HMO prior to rendering the services. You are requested to notify the HMO for all services below noting Prenotification only.

If you have questions or concerns the HMO is ready to assist you. Don’t hesitate to call Member Services at the telephone number shown on the back of the ID Card. The HMO’s Representatives will respond to any inquiry promptly.

There is no penalty to you when the treating physician in the HMO’s network fails to obtain Preapproval from the HMO or fails to prenotify the HMO.

1. **ALL INPATIENT ADMISSIONS**
   a. Acute Rehabilitation
   b. Hospice
   c. Maternity (Prenotification only)
   d. Mental Health Care and Serious Mental Illness Health Care
   e. Routine Costs Associated with Clinical Trials
   f. Skilled Nursing Facility
   g. Substance Abuse
   h. Surgical/Non-Surgical (including Transplants)

2. **OUTPATIENT SERVICES**
   a. Ambulance Services – non-Emergency
   b. Birth Center (Prenotification only)
   c. Day Rehabilitation Program
   d. Dental Services as a result of Accidental Injury
   e. Durable Medical Equipment (items over $500 billed amount, including repairs and replacements, and all rentals). Preapproval is not required for oxygen, diabetic supplies and unit dose medication for nebulizers.
   f. Home Health Care
   g. Infusion Therapy in a home setting

**IMPORTANT: THE LIST OF INFUSION THERAPY DRUGS LISTED BELOW IS SUBJECT TO PREAPPROVAL. THIS LIST IS SUBJECT TO CHANGE AS NEW INFUSION DRUGS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.**

   h. Infusion Therapy in an Outpatient Facility or office setting for the following Infusion Therapy drugs:
      Aldurazyme, Aredia, Avastin, Boniva, Ceredase, Cerezyme, Elaprase, Erbitux, Fabrazyme, Genasense, Herceptin, IVIG, Myozyme, Orenica, Remicade, Respigam, Tysabri.

   i. Mental Health Care and Serious Mental Illness Health Care – Intensive Outpatient Program and Partial Hospitalization services
   j. Comprehensive Pain Management Programs (including epidural injections)
   k. Private Duty Nursing
   l. Prosthetics and Orthotics (items over $500 billed amount, including repairs and replacements) Preapproval is not required for ostomy supplies.
m. Routine Costs Associated With Qualifying Clinical Trials  
   n. Sleep Studies  
   o. Specialist Services - for Referrals by Primary Care Physicians to Non-Participating Providers  
   p. Substance Abuse (including Partial Hospitalization services)

3. **DIAGNOSTIC SERVICES** (when required)  
   a. Computed Tomography (CT and CTA Scans)  
   b. Magnetic Resonance Angiography (MRA)  
   c. Magnetic Resonance Imaging (MRI)  
   d. Nuclear Cardiac Studies  
   e. Positron Emission Tomography (PET Scan)

4. **SURGICAL PROCEDURES** (regardless of place of service)  
   a. Cataract Surgery  
   b. Hysterectomy  
   c. Knee arthroscopy  
   d. Nasal Surgery for submucous resection and septriaplasty  
   e. Obesity Surgery  
   f. Orthognathic Surgery procedures  
   g. Transplants (except cornea)  
   h. Uvulopalatopharyngoplasty (including laser-assisted)

5. **POTENTIALLY COSMETIC / RECONSTRUCTIVE PROCEDURES**  
   a. Abdominoplasty  
   b. Augmentation mammoplasty  
   c. Blepharoplasty/Brow Lift  
   d. Chemical Peels and Dermabrasion  
   e. Excision of redundant skin  
   f. Keloid Removal  
   g. Lipectomy/Liposuction  
   h. Mastopexy  
   i. Otoplasty  
   j. Panniculectomy  
   k. Reduction Mammoplasty  
   l. Removal or Reinsertion of breast implants  
   m. Repair of ear lacerations  
   n. Rhinoplasty  
   o. Scar Revision  
   p. Subcutaneous Mastectomy for Gynecomastia  
   q. Surgery for varicose veins

**IMPORTANT:** THE ABOVE LIST OF SERVICES AND SUPPLIES REQUIRING PREAPPROVAL OR PRENOTIFICATION IS SUBJECT TO CHANGE. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.
In addition to the Preapproval requirements listed above for certain services and supplies, you should contact the HMO for certain categories of treatment (listed below) so that you will know prior to receiving treatment whether it is a Covered Service. These categories of treatment (in any setting) include:

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

2. Any procedure, treatment, drug or device that represents “new or emerging technology”, including Infusion Therapy drugs newly approved by the FDA; and

3. Services that might be considered Experimental/Investigative.

The treating physician in the HMO’s network will assist you in determining whether a proposed treatment falls into one of these three categories.
BIOTECH/SPECIALTY INJECTABLE DRUGS REQUIRING PREAPPROVAL RIDER

For the services listed below, your Primary Care Physician or HMO Participating Specialist is required to obtain Preapproval from the HMO prior to rendering the services.

There is no penalty to you when your Primary Care Physician or HMO Participating Specialist fails to obtain Preapproval from the HMO or fails to notify the HMO.

ALL BIOTECH/SPECIALTY INJECTABLE DRUGS

Biotech/Specialty Injectables are injectable medications which are included in the following list of Biotech/Specialty Injectables. All of the brand name Biotech/Specialty Injectables and their generic equivalents listed below require Preapproval:

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

Antiretroviral Agents:
- Fuzeon

Botulinum Toxin Agents:
- Botox, Myobloc

Central Nervous System Agents:
- Apokyn, Imitrex Injection, Vivitrol

Endocrine/Metabolic Agents:
- Eligard, Faslodex, Forteo, Lupron, Sandostatin LAR, Somavert, Somatuline Depot, Supprelin LA, Thyrogen, Trelstar, Vantas, Viadur, Zoladex

Growth Hormones and Related Agents:
- Genotropin, Humatrope, Increlex, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Serostim LQ, Tev-Tropin, Zorbtive

Hematopoietic Agents:
- Aranesp, Epogen, Leukine, Neulasta, Neumega, Neupogen, Procrit

Hepatitis/Interferon Agents:
- Actimmune, Alferon N, Infergen, Intron A, Pegasys, PEG-Intron, Roferon-A

Hyaluronate Agents:
- Euflexxa, Hyalgan, Orthovisc, Supartz, Synvisc

Immunological Modifiers:
- Amevive, Enbrel, Humira, Kineret, Raptiva

Intra-Ocular Agents:
- Lucentis, Macugen, Vitrasert

Multiple Sclerosis Agents/Interferon Beta Agents:
- Avonex, Betaseron, Copaxone, Rebif

Respiratory Agents:
- Synagis, Xolair

THIS LIST OF BIOTECH/SPECIALTY MEDICATIONS REQUIRING PREAPPROVAL IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.
KEYSTONE HEALTH PLAN EAST, INC.
(hereafter called "Keystone" or “the HMO”)

EVIDENCE OF COVERAGE RIDER

This Rider modifies your HMO benefit description material with updates for certain changes to your plan’s Covered Services. The Effective Date of these changes is the later of January 1, 2011 or:

(a) the Contract Date;
(b) the Member’s Effective Date of Coverage; or
(c) the Group Master Contract’s anniversary date coinciding with or the next following the effective date of the change.

I. The following changes are made with regard to BlueCard Disclosure:

A. Your MEMBER HANDBOOK is revised as follows:

1. The provision entitled “Out-of-Area Services” is added to the A Summary of HMO Features section:

Out-of-Area Services

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

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

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

A. BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Keystone will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.
The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your SCHEDULE OF COST SHARING AND LIMITATIONS.

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

See the PREAPPROVAL FOR NON-PARTICIPATING PROVIDERS section of your Member Handbook for information regarding services provided by Non-Participating Providers.

2. The Emergency and Urgent Care section is revised as follows:

a. The provision entitled “The BlueCard Program” is expanded to include the following:

Emergency Care Services: If you experience a Medical Emergency while traveling outside the Keystone Service Area, go to the nearest Emergency or Urgent Care facility.

b. The provision entitled “Additional Information about the BlueCard Program” is replaced with the following:

Additional Information about the BlueCard Program

Whenever you access covered healthcare services outside Keystone’s Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

* The billed covered charges for your covered services; or

* The negotiated price that the Host Blue makes available to Keystone.

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.
II. The following changes are made with regard to **Diabetic Insulin Pumps**:

1. The “**Diabetic Equipment and Supplies**” provision under the **Description of Covered Services** section of your **MEMBER HANDBOOK** is revised to replace the first paragraph with the following:

   **Diabetic Equipment and Supplies**

   Benefits shall be provided for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider, subject to any Deductible, Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits. If this Plan provides benefits for prescription drugs (other than coverage for insulin and oral agents only), certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy if available, subject to the cost-sharing arrangements applicable to the prescription drug addendum. Certain diabetic equipment is not available at a pharmacy. In these instances, the diabetic equipment will be provided under the Durable Medical Equipment benefit subject to the cost-sharing arrangements applicable to Durable Medical Equipment.

III. The following changes are made with regard to **Place of Service** language:

1. The language pertaining to “**Place of Service**” under the **Exclusions-What is Not Covered** section of your **MEMBER HANDBOOK** is replaced with the following:

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

IV. The following changes are made with regard to **Bariatric Surgery** language:

1. The language pertaining to “**Bariatric Surgery**” under the **Exclusions-What is Not Covered** section of your **MEMBER HANDBOOK** is replaced with the following:

   - For treatment of obesity, except for surgical treatment of obesity when the HMO:
     
     A. Determines the surgery is Medically Necessary; and
     
     B. The surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the HMO or another carrier. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered.

   The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Member.

   This exclusion does not apply to nutrition counseling visits/sessions as described in the Nutrition Counseling for Weight Management provision in this Member Handbook;

V. The following changes are made with regard to **Specialty Drug**:

A. Your **MEMBER HANDBOOK** is revised to incorporate the following changes

1. The term “Biotech/Specialty Injectables” is globally replaced with the term “**Specialty Drugs**” throughout your Member Handbook.
2. The term “Standard Injectables” is globally replaced with the term “Standard Injectable Drugs” throughout your Member Handbook.

3. The Outpatient Covered Services sub-section of the Description of Covered Services section is revised as follows:
   
a. The provision for Injectable Medications is replaced with the following:

   **Injectable Medications**
   
   Benefits will be provided for injectable medications required in the treatment of an injury or illness administered by a Participating Professional Provider.

   (A) **Specialty Drug** - Refers to a medication that meets certain criteria including, but is not limited to, the drug is used in the treatment of a rare, complex, or chronic disease (e.g., hemophilia); a high level of involvement is required by a healthcare provider to administer the drug; complex storage and/or shipping requirements are necessary to maintain the drug’s stability; the drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance; access to the drug may be limited.

   Preapproval is required for those Specialty Drugs noted in the Preapproval list, which is available online at www.ibxpress.com/My Benefits Information tab, or by calling Customer Service at the phone number listed on your ID Card. The purchase of any Specialty Drug is subject to cost sharing as shown on the SCHEDULE OF COST SHARING & LIMITATIONS.

   (B) **Standard Injectable Drug** - refers to a medication that is either injectable or infusible but is not defined by the company to be a Self-Injectable Drug or a Specialty Drug. Standard Injectable Drugs include, but are not limited to: allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Participating Professional Provider.

   (C) **Self-Injectable Drugs** - for self-injectable medication coverage, please refer to the Exclusions – What is Not Covered section and the Insulin and Oral Agents provision of this section.

   b. The description of “C. Infusion Therapy” under Therapy Services provision is replaced with the following:

   **Infusion Therapy**
   
   Treatment including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration by a healthcare provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of healthcare provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the HMO.
4. The **Important Definitions** section is expanded to include the following:

- **INFUSION THERAPY** - Treatment including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration by a healthcare provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of healthcare provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the HMO.

- **SPECIALTY DRUG** – A medication that meets certain criteria including, but not limited to:
  1. The drug is used in the treatment of a rare, complex, or chronic disease (eg, hemophilia).
  2. A high level of involvement is required by a healthcare provider to administer the drug.
  3. Complex storage and/or shipping requirements are necessary to maintain the drug’s stability.
  4. The drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance.
  5. Access to the drug may be limited.

- **STANDARD INJECTABLE DRUG** – A medication that is either injectable or infusible but is not defined by the company to be a Self-Injectable Drug or a Specialty Drug. Standard Injectable Drugs include, but are not limited to: allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Participating Professional Provider.

B. Your **SCHEDULE OF COST SHARING & LIMITATIONS** is revised to incorporate the following changes:

   1. The sub-section **Injectable Medications** is replaced with the following:

   **INJECTABLE MEDICATIONS**
   
<table>
<thead>
<tr>
<th>Specialty Drugs</th>
<th>Applicable Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Injectable Drugs</td>
<td>Applicable Cost Sharing</td>
</tr>
</tbody>
</table>

VI. The following changes are made with regard to **Services and Supplies Requiring Preapproval or Notification**:

   A. The **Services and Supplies Requiring Preapproval or Prenotification** section of your **MEMBER HANDBOOK** is removed in its entirety.

   B. All references to the **SERVICES AND SUPPLIES REQUIRING PREAPPROVAL OR PRENOTIFICATION** section throughout the **MEMBER HANDBOOK** and the **SCHEDULE OF COST SHARING & LIMITATIONS** are globally replaced with the following sentence:
To access a complete list of services that require Preapproval, log onto www.ibxpress.com/My Benefits Information tab, or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

VII. The following changes are made with regard to **Routine Costs of Clinical Trials**:

A. The definition of “**Qualifying Clinical Trial**” under the **Important Definitions** section of your **MEMBER HANDBOOK** is replaced with the following:

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

A. It investigates a service that falls within a benefit category of this plan.

B. It is not specifically excluded from coverage.

C. Based on currently available scientific information, the drug, biological product, device, medical treatment, therapy or procedure being studied may be of benefit in treating the disease or condition for which the drug, biological product, device, medical treatment, therapy or procedure is being prescribed.

D. The Member is a subject enrolled in a phase II, III or IV clinical trial, or a phase I cancer clinical trial.

E. It does not duplicate existing studies.

F. It is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial.

G. It is designed and conducted according to appropriate standards of scientific integrity.

H. It complies with Federal regulations relating to the protection of human subjects.

I. It has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease.

J. One of the following applies:

1. It is funded by, or supported by centers or cooperative groups that are funded by one of the following:
   a. the National Institutes of Health (NIH)
   b. Centers for Disease Control and Prevention (CDC)
   c. Agency for Healthcare Research and Quality (AHRQ)
   d. Centers for Medicare and Medicaid Services (CMS)
   e. a research arm of the Department of Defense (DOD) or
   f. Department of Veterans Affairs (VA).

2. It is conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA.

K. It is conducted by a Primary Care Physician, Participating Professional Provider or a Non-Participating Specialist, when Preapproved by the HMO and conducted in a Participating Provider facility. If there is no comparable Clinical Trial (as defined
above) being performed by, and in, Participating Providers, then the HMO will consider the services by Non-Participating Providers as covered. See ACCESS TO PRIMARY, SPECIALIST, AND HOSPITAL CARE for procedures for obtaining Preapproval for use of a Non-Participating Provider.

In the absence of meeting the criteria listed in A. – K. above, the Clinical Trial must be approved by the HMO as a Qualifying Clinical Trial.

VIII. The following changes are made with regard to Outpatient Substance Detoxification Treatment:

A. Your MEMBER HANDBOOK is revised to incorporate the following changes:

1. The definition of “Detoxification” under the Important Definitions section is replaced with the following:

   DETOXIFICATION - the process whereby an alcohol or drug intoxicated, or alcohol or drug dependent person is assisted, in a facility licensed by the Department of Health, or in case of opiates, by an appropriately licensed behavioral health provider in an ambulatory setting. This treatment process will occur through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

2. The description of “Substance Abuse Treatment” under the Inpatient/Outpatient Covered Services sub-section of the Description of Covered Services section is revised as follows:

   a. Item B. is replaced with the following. The remainder of the description remains as it is:

   B. Outpatient Substance Abuse Treatment

   Benefits are provided for Covered Services during an Outpatient Substance Abuse Treatment visit/session:

   1. For the diagnosis and medical treatment of Substance Abuse, including Detoxification by the appropriately licensed behavioral health provider;

   2. At a Participating Facility Provider that is a Behavioral Health/Substance Abuse Provider.

   Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling during an Outpatient Substance Abuse Treatment visit/session in a Substance Abuse Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Substance Abuse Provider.

   Outpatient Substance Abuse Treatment Covered Services include:

   1. Diagnostic services, including psychiatric, psychological and medical laboratory tests;

   2. Services provided by the Behavioral Health/Substance Abuse Providers on staff;

   3. Rehabilitation therapy and counseling;
4. Family counseling and intervention; and

5. Medication management and use of equipment and supplies provided by the Substance Abuse Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Substance Abuse Provider.

The Evidence of Coverage is changed only as stated in this Rider. All provisions of the Evidence of Coverage not changed by this Rider still apply.

KEYSTONE HEALTH PLAN EAST, INC.
Letter Amendment

Dependents to Age 26:

The Definition of Eligible Dependent will include adult children until age 26 regardless of financial dependency, residency, student status, and employment status. This does not include coverage for spouses or children of Eligible Dependents.

Annual and Lifetime Dollar Maximums:

All lifetime and annual dollar benefit maximums for essential benefits have been removed.

Removal of Pre-Existing Condition for Dependent Children Under the Age of 19:

If a pre-existing condition is applicable to your health benefits plan the pre-existing condition exclusion will not apply to Covered Persons under the age of 19.

Rescission of Coverage:

A Covered Person’s/Member’s coverage will only be rescinded for fraud, intentional misrepresentation of material fact or nonpayment of premiums.

Appeals:

If your health benefits plan does not currently include an external appeal process the plan has been revised to include an external appeal process.

Emergency Care

Payment for emergency services provided by out-of-network providers will be the greater of (1) the median of the amounts paid to in-network providers for emergency services; (2) the amount paid to non-participating providers; or (3) the amount paid by Medicare.
Evidence of Coverage

Table of Contents

Required Disclosure of Information .......................... 3.2-2
Welcome ......................................................... 3.2-3
  Your ID Card ................................................ 3.2-3

Using the HMO System –
A Summary of Things To Remember ......................... 3.2-4
  Your Primary Care Physician .................................. 3.2-4
  When You Need Care From a Specialist ...................... 3.2-4
  Immediate Care ............................................. 3.2-4
  Continuing Care ............................................ 3.2-4
  Preapproval .................................................. 3.2-4
  Participating Providers ...................................... 3.2-4
  Medical Technology Assessment ............................. 3.2-5
  Prescription Drugs Under the Plan ......................... 3.2-5
  Disease Management and Decision Support Program ........ 3.2-5

Claims Procedures ............................................. 3.2-7
  Notice of Claim ............................................. 3.2-7
  Proof of Loss .............................................. 3.2-7
  Claim Forms ................................................. 3.2-7
  Submission of Claim Forms ................................... 3.2-7
  Timely Payment of Claims .................................... 3.2-8

Access To Primary Care, Specialist and Hospital Care .......... 3.2-9
  Direct Access to Certain Care ................................. 3.2-9
  How to Obtain a Specialist Referral .......................... 3.2-9
  How to Obtain a Standing Referral ............................ 3.2-10
  Designating a Referred Specialist as Your Primary Care Physician .......................................................... 3.2-10
  Changing Your Primary Care Physician ....................... 3.2-11
  Changing Your Referred Specialist ............................ 3.2-11
  Continuity of Care ........................................... 3.2-12
  Preapproval for Non-Participating Providers .................. 3.2-12
  Hospital Admissions .......................................... 3.2-13
  Recommended Plan of Treatment .............................. 3.2-13
  Special Circumstances ....................................... 3.2-14
  Member Liability ............................................. 3.2-14
  Limitation of the HMO’s Liability ............................ 3.2-14
  Right To Recover Payments Made In Error .................... 3.2-14

Emergency, Urgent Care, Follow-Up Care ......................... 3.2-15
  What is Emergency Services? .................................. 3.2-15
  Medical Screening Evaluation .................................. 3.2-15
  What is Urgent Care? ......................................... 3.2-15
  What is Follow-Up Care? ....................................... 3.2-16
  Urgent Care and Follow-Up Care Outside Keystone’s Service Area –
  The BlueCare Program’s ....................................... 3.2-16
  Continuing Care .............................................. 3.2-18
  Auto or Work-Related Accidents ................................ 3.2-19

Away From Home Care Program®
Guest Membership Benefits .................................. 3.2-20
  Traveling Outside the HMO’s Service Area for Longer Periods – The Away From Home Care Program Guest Membership Benefits ........................................ 3.2-20
  When You Don’t Use the BlueCard or Away From Home Care Guest Membership Programs ........................................ 3.2-21

Eligibility, Change and Termination
Rules Under the Plan ........................................... 3.2-22
  Eligibility ..................................................... 3.2-22
  When to Notify the HMO of a Change ......................... 3.2-23
  Termination of Coverage ...................................... 3.2-25

Continuation and Conversion of Coverage ......................... 3.2-27
  Continuation ................................................ 3.2-27
  Conversion .................................................. 3.2-27

Your Membership Rights and Responsibilities .................... 3.2-29
  Coordination of Benefits ..................................... 3.2-31
  Subrogation .................................................. 3.2-32

Member Complaint Appeal and Grievance Appeal Process ........ 3.2-33

Additional Information About How We Reimburse Providers .......... 3.2-44

Description of Covered Services ................................ 3.2-46
  Primary and Preventive Care .................................. 3.2-46
  Inpatient Covered Services .................................... 3.2-47
  Inpatient/Outpatient Covered Services ......................... 3.2-50
  Outpatient Covered Services .................................. 3.2-56

Exclusions – What Is Not Covered ................................ 3.2-66

Important Definitions .......................................... 3.2-73

General Information ........................................... 3.2-96
  Other Coverage ............................................. 3.2-96
  Independent Corporation ....................................... 3.2-96


**Required Disclosure of Information**

State law requires that Keystone Health Plan East, Inc. (“Keystone” or “the HMO”) make the following information available to you when you make a request in writing to the HMO.

1. A list of the names, business addresses and official positions of the membership of the Board of Directors or Officers of the HMO.

2. The procedures adopted to protect the confidentiality of medical records and other enrollee information.

3. A description of the credentialing process for health care Providers.

4. A list of the participating health care Providers affiliated with participating Hospitals.

5. Whether a specifically identified drug is included or excluded from coverage.

6. A description of the process by which a health care Provider can Prescribe any of the following when either:
   (1) the Drug Formulary’s equivalent has been ineffective in the treatment of the enrollee’s disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.
   
   A. Specific drugs;
   
   B. Drugs used for an off-label purpose; and
   
   C. Biologicals and medications not included in the Drug Formulary for Prescription Drugs or biologicals.

7. A description of the procedures followed by the HMO to make decisions about the experimental nature of individual drugs, medical devices or treatments.

8. A summary of the methodologies used by the HMO to reimburse for health care services. (This does not mean that the HMO is required to disclose individual contracts or the specific details of financial arrangements we have with health care Providers.)

9. A description of the procedures used in the HMO’s quality assurance program.

10. Other information that the Pennsylvania Department of Health or the Insurance Department may require.

**Confidentiality And Disclosure Of Medical Information**

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

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

Thank you for joining Keystone Health Plan East, Inc. ("Keystone" or "the HMO"). Our goal is to provide you with access to quality health care coverage. This Evidence of Coverage ("Member Handbook") is a summary of your benefits and the procedures required in order to receive the benefits and services to which you are entitled. Your specific benefits covered by the HMO are described in the DESCRIPTION OF COVERED SERVICES section of this Member Handbook.

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

Please read your Member Handbook thoroughly and keep it handy. It will answer most of your questions regarding the HMO’s procedures and services. If you have any other questions, call the HMO’s Member Services Department ("Member Services") at the telephone number shown on your ID Card. Or you may write to Member Services at:

Keystone Health Plan East
P.O. Box 8339
Philadelphia, PA 19101-8339

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

Your ID Card

Listed below are some important things to do and to remember about your ID Card:

- **Check** the information on your ID Card for completeness and accuracy.
- **Check** that you received one ID Card for each enrolled family Member.
- **Check** that the name of the Primary Care Physician (or office) you selected is shown on your ID Card. Also, please check the ID Card for each family Member to be sure the information on it is accurate.
- **Call** Member Services if you find an error or lose your ID Card.
- **Carry** your Member ID Card at all times. You must present your ID Card whenever you receive Medical Care.

On the reverse side of the ID Card, you will find information about medical services, especially useful in Emergencies. There is even a toll-free number for use by Hospitals if they have questions about your coverage.
Using The HMO System

The HMO program is different from traditional health insurance coverage. In addition to covering health care services, access is provided to your Medical Care through your Primary Care Physician. All medical treatment begins with your Primary Care Physician. (Under certain circumstances, continuing care by a Non-Participating Provider will be treated in the same way as if the Provider were a Participating Provider. See “Continuity of Care” appearing later in the Member Handbook.)

Because your Primary Care Physician is the key to using the HMO program, it is important to remember the following:

- **Always call your Primary Care Physician first,** before receiving Medical Care (except for conditions requiring Emergency Services). Please schedule routine visits well in advance.

- **When you need Specialist Services,** your Primary Care Physician will give you a written or electronic Referral for specific care or will obtain a Preapproval from the HMO when required. A Standing Referral may be available to you if you have a life-threatening, degenerative or disabling disease or condition. Female Members may visit any participating obstetrical/gynecological Specialist without a Referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care or problem-related obstetrical/gynecological conditions except in the case of treatment for reproductive endocrinology, infertility or gynecological oncology. Your Primary Care Physician must obtain a Preapproval for Specialist Services provided by Non-Participating Providers.

- **Your Primary Care Physician provides coverage 24 hours a day, 7 days a week.**

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

- **Some services must be authorized by your Primary Care Physician or Preapproved by the HMO.** Your Primary Care Physician or Referred Specialist works with the HMO’s Care Management and Coordination team during the Preapproval process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. Services that require Preapproval are noted in the SERVICES AND SUPPLIES REQUIRING PREAPPROVAL RIDER. You have the right to appeal any decisions through the Member Complaint and Appeal Process. Instructions for the appeal will be described in the denial notifications.

- **All services must be received from HMO Participating Providers unless Preapproved by the HMO, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area.** See “Access to Primary, Specialist and Hospital Care” for procedures for obtaining Preapproval for use of a Non-Participating Provider. Use your Provider Directory to find out more about the individual Providers, including Hospitals, Primary Care Physicians, Referred Specialists and their affiliated Hospitals. It includes a foreign language index to help you locate a Provider who is fluent in a particular language. The directory also lists whether the Provider is accepting new patients.

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

• **Prescription Drugs are covered under your HMO program.** Under this Plan, Prescription Drugs, including medications and biologicals, are Covered Services or Supplies when ordered during your Inpatient Hospital stay. In addition, if you do not have Prescription Drug coverage under a HMO Prescription Drug Rider, the HMO will provide coverage for insulin and oral agents for use when you are not an Inpatient.

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

Prescription Drug Benefits do not cover over-the-counter drugs except insulin. Additionally, Prescription Drug benefits are subject to quantity level limits as conveyed by the Food and Drug Administration (“FDA”) or the HMO's Pharmacy and Therapeutics Committee.

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

You, or your Physician acting on your behalf, may appeal any denial of benefits or application of higher Copayments through the **MEMBER COMPLAINT APPEAL AND GRIEVANCE APPEAL PROCESS** described later in this Handbook.

• **Disease Management and Decision Support programs help Members to be effective partners in their health care** by providing information and support to Members with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Members with certain chronic diseases, intervening with specific information or support to follow PCP’s and Referred Specialist treatment plan, and measuring clinical and other outcomes. Decision Support involves identifying Members who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their PCP's and Referred Specialist. Decision Support also includes the availability of general health information, personal health coaching, PCP’s and Referred Specialist information, or other programs to assist in health care decisions.
Disease Management interventions are designed to help Members manage their chronic condition in partnership with their PCP’s and Referred Specialist. Disease Management programs, when successful, can help such Members avoid long term complications, as well as relapses that would otherwise result in Hospital or Emergency room care. Disease Management programs also include outreach to Members to obtain needed preventive services, or other services recommended for chronic conditions. Information and support may occur in the form of telephonic health coaching, print, audio library or videotape, or Internet formats.

The HMO will utilize medical information such as claims data to operate the Disease Management or Decision Support program, e.g., to identify Members with chronic disease, to predict which Members would most likely benefit from these services, and to communicate results to Member’s treating PCP’s and Referred Specialist. The HMO will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Member in Disease Management or Decision Support programs is voluntary. A Member may continue in the Disease Management or Decision Support program until any of the following occurs: (1) The Member notifies the HMO that they decline participation; or (2) The HMO determines that the program, or aspects of the program, will not continue.
Claim Procedures

If claim submission by a Member is required in order to receive payment for Benefits under this Handbook, the following provisions will apply.

Notice of Claim

The HMO will not be liable for any claims under this Member Handbook unless proper notice is furnished to the HMO that Covered Services in this Member Handbook have been rendered to a Member. Written notice of a claim must be given to the HMO within twenty (20) days, or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the HMO that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a claim to the HMO.

The Member can give notice to the HMO by calling or writing to Member Services. The telephone number and address of Member Services can be found on the Member’s ID Card. A charge shall be considered Incurred on the date a Member receives the Covered Service for which the charge is made.

Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the HMO. Written proof of loss must be provided to the HMO within ninety (90) days after the charge for Covered Services is Incurred. Proof of loss must include all data necessary for the HMO to determine Benefits. Failure to submit a proof of loss to the HMO within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the HMO be required to accept a proof of loss later than twelve (12) months after the charge for Covered Services is Incurred.

Claim Forms

If a Member (or if deceased, by his/her personal representative) is required to submit a proof of loss for Benefits under this Member Handbook, it must be submitted to the HMO on the appropriate claim form. The HMO, upon receipt of a notice of claim will, within fifteen (15) days following the date notice of claim is received, furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within fifteen (15) days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this Subsection as to filing a proof of loss upon submitting, within the time fixed in this Subsection for filing proofs of loss, itemized bills for Covered Services as described below. Itemized bills may be submitted to the HMO at the address appearing on the Member’s ID Card. Itemized bills cannot be returned.

Submission of Claim Forms

For Member-submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to the HMO at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for Benefits provided under this Member Handbook.
To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

1. Person or organization providing the service or supply
2. Type of service or supply
3. Date of service or supply
4. Amount charged
5. Name of patient

A request for payment of a claim will not be reviewed and no payment will be made unless all the information and evidence of payment required on the claim form has been submitted in the manner described above. The HMO reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

**Timely Payment of Claims**

Claims payment for Benefits payable under this Member Handbook will be processed immediately upon receipt of proper proof of loss.
Access To Primary Care, Specialist and Hospital Care

Direct Access to Certain Care

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

A. Emergency Services;

B. The following Obstetrical/Gynecological Care:
   A Female Member may seek care directly from a participating obstetrical/gynecological Specialist for: routine maternity care; routine gynecological care; elective abortion; or other gynecological care. This is true whether the visit is for preventive care, problem-related obstetrical/gynecological conditions or routine obstetrical/ gynecological care. This does not include specialty care provided by a reproductive endocrinologist, infertility specialist, or gynecologic oncologist.

C. Mammograms

D. Mental Health Care, Serious Mental Illness Health Care and Substance Abuse Treatment

E. Inpatient Hospital Services that require Preapproval. This does not include a maternity Inpatient Stay;

F. Dialysis services performed in a Participating Facility Provider or by a Participating Professional Provider.

How To Obtain a Specialist Referral

Always consult your Primary Care Physician first when you need Medical Care.

If your Primary Care Physician refers you to a Referred Specialist or facility just follow these steps:

• Your Primary Care Physician will give you a written Referral form or supply an electronic form which indicates the services authorized.

• Your Referral is valid for ninety (90) days from issue date as long as you are a Member.

• You can give this form to the Referred Specialist or facility or it can be sent electronically to the Referred Specialist or facility before the services are performed. Only services authorized on the Referral form will be covered.

• Any additional Medically Necessary treatment recommended by the Referred Specialist beyond the ninety (90) days from the date of issue of the initial Referral will require another written or electronic Referral from your Primary Care Physician.

• You must be an enrolled Member at the time you receive services from a Referred Specialist or Non-Participating Provider in order for services to be covered.

See the Preapproval for Non-Participating Providers section of your Handbook for information regarding services provided by Non-Participating Providers.
**How To Obtain a Standing Referral**

If you have a life-threatening, degenerative or disabling disease or condition, you may receive a Standing Referral to a Referred Specialist to treat that disease or condition. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral is granted upon review of a treatment plan by the HMO and in consultation with your Primary Care Physician.

Follow these steps to initiate your Standing Referral request.

A. Call Member Services at the telephone number shown on your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Care Management and Coordination to obtain a “Standing Referral Request” form.)

B. A “Standing Referral Request” form will be mailed or faxed to the requestor.

C. You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to Care Management and Coordination.

D. Care Management and Coordination will either approve or deny the request for the Standing Referral. You, your Primary Care Physician and the Referred Specialist will receive notice of the approval or denial in writing. The notice will include the time period for the Standing Referral.

**If the Standing Referral is Approved**

If the request for the Standing Referral to a Referred Specialist is approved, the Referred Specialist, your Primary Care Physician and you will be informed in writing by Care Management and Coordination. The Referred Specialist must agree to abide by all the terms and conditions that the HMO has established with regard to Standing Referrals. This includes, but is not limited to, the need for the Referred Specialist to keep your Primary Care Physician informed of your condition. When the Standing Referral expires, you or your Primary Care Physician will need to contact Care Management andCoordination and follow the steps outlined above to see if another Standing Referral will be approved.

**If the Standing Referral is Denied**

If the request for a Standing Referral is denied, you and your Primary Care Physician will be informed in writing. You will be given information on how to file a formal complaint, if you so desire.

**Designating a Referred Specialist as Your Primary Care Physician**

If you have a life-threatening, degenerative or disabling disease or condition, you may have a Referred Specialist named to provide and coordinate both your primary and specialty care. The Referred Specialist will be a Physician with clinical expertise in treating your disease or condition. It is required that the Referred Specialist agrees to meet the plan’s requirements to function as a Primary Care Physician.
Follow these steps to initiate your request for your Referred Specialist to be your Primary Care Physician.

A. Call Member Services at the telephone number shown on your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Care Management and Coordination to initiate the request.)

B. A “Request for Specialist to Coordinate All Care” form will be mailed or faxed to the requestor.

C. You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to Care Management and Coordination.

D. The Medical Director will speak directly with your Primary Care Physician and the selected Referred Specialist to apprise all parties of the primary services that the Referred Specialist must be able to provide in order to be designated as a Member's Primary Care Physician. If Care Management and Coordination approves the request, it will be sent to the Provider Service area. That area will confirm that the Referred Specialist meets the same credentialing standards that apply to Primary Care Physicians. (At the same time, you will be given a Standing Referral to see the Referred Specialist.)

If the Referred Specialist as Primary Care Physician Request is Approved

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

If the Referred Specialist as Primary Care Physician Request is Denied

If the request to have a Referred Specialist designated to provide and coordinate your primary and specialty care is denied, you and your Primary Care Physician will be informed in writing. You will be given information on how to file a formal complaint, if you so desire.

Changing Your Primary Care Physician

You may change your Primary Care Physician up to two times within each calendar year. To do so, simply call Member Services at the telephone number shown on your ID Card. Your change will be effective on the first of the month following your phone call. Please remember to have your medical records transferred to your new Primary Care Physician.

If the participating status of your Primary Care Physician changes, you will be notified in order to select another Primary Care Physician.

Changing Your Referred Specialist

You may change the Referred Specialist to whom you have been referred by your Primary Care Physician or for whom you have a Standing Referral. To do so, ask your Primary Care Physician to recommend another Referred Specialist before services are performed. Or, you may call Member Services at the telephone number shown on your ID Card. Remember, only services authorized on the Referral form will be covered.

If the participating status of a Referred Specialist you regularly visit changes, you will be notified to select another Referred Specialist.
**Continuity of Care**

You have the option, if your Physician agrees to be bound by certain terms and conditions as required by the HMO, of continuing an ongoing course of treatment with that Physician. This continuation of care shall be offered through the current period of active treatment for an acute condition or through the acute phase of a chronic condition or for up to ninety (90) calendar days from the notice that the status of your Physician has changed or your Effective Date of Coverage when:

A. Your Physician is no longer a Participating Provider because the HMO terminates its contract with that Physician, for reasons other than cause; or

B. You first enroll in the Group plan and are in an ongoing course of treatment with a Non-Participating Provider.

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

Follow these steps to initiate your continuity of care:

- Call Member Services at the number on your ID Card and ask for a “Request for Continuation of Treatment” form.
- The “Request for Continuation of Treatment” form will be mailed or faxed to you.
- You must complete the form and send it to Care Management and Coordination at the address that appears on the form.

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

You will be notified when the participating status of your Primary Care Physician changes so that you can select another Primary Care Physician.

**Preapproval for Non-Participating Providers**

The HMO may approve payment for Covered Services provided by a Non-Participating Provider if you have:

A. First sought and received care from a Participating Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the Non-Participating Provider that you have requested. (Your Primary Care Physician is required to obtain Preapproval from the HMO for services provided by a Non-Participating Provider.)

B. Been advised by the Participating Provider that there are no Participating Providers that can provide the requested Covered Services; and

C. Obtained authorization from the HMO prior to receiving care. The HMO reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.
If the HMO approves the use of a Non-Participating Provider, you will not be responsible for the difference between the provider’s billed charges and the HMO’s payment to the Provider but you will be responsible for applicable Copayments, Coinsurance and/or deductibles. Applicable program terms including Medical Necessity, Referrals and Preapproval by the HMO, when required, will apply.

**Hospital Admissions**

A. If you need hospitalization or outpatient Surgery, your Primary Care Physician or Referred Specialist will arrange admission to the Hospital or outpatient surgical facility on your behalf.

B. Your Primary Care Physician or Referred Specialist will coordinate the Preapproval for your outpatient Surgery or Inpatient admission with the HMO, and the HMO will assign a Preapproval number. Preapproval is not required for a maternity Inpatient Stay.

C. You do not need to receive a written or electronic Referral from your Primary Care Physician for Inpatient Hospital Services that require Preapproval.

Upon receipt of information from your Primary Care Physician or Referred Specialist, Care Management and Coordination will evaluate the request for hospitalization or outpatient Surgery based on clinical criteria guidelines. Should the request be denied after review by a HMO Medical Director, you, your Primary Care Physician or Referred Specialist have a right to appeal this decision through the Grievance appeal process.

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

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

**Recommended Plan of Treatment**

You agree, when joining the HMO, to receive care according to the recommendations of your Primary Care Physician. You have the right to give your informed consent before the start of any procedure or treatment. You also have the right to refuse any drugs, treatment or other procedure offered to you by the HMO providers, and to be informed by your Physician of the medical consequences of your refusal of any drugs, treatment, or procedure.

The HMO and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended Plan of Treatment, the HMO will not be responsible for the costs of further treatment for that condition and you will be so notified. You may use the Grievance appeal process to have your case reviewed, if you so desire.
**Special Circumstances**

In the event that Special Circumstances result in a severe impact to the availability of Providers and services, to the procedures required for obtaining benefits for Covered Services under the Contract and described in this Member Handbook (e.g., obtaining Referrals, use of Participating Providers), or to the administration of the Contract by the HMO, the HMO may, on a selective basis, waive certain procedural requirements of the Contract or the Member Handbook. Such waiver shall be specific as to the requirements that are waived and shall last for such period of time as is required by the Special Circumstances as defined below.

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

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

A. a major disaster;
B. an epidemic;
C. a pandemic;
D. the complete or partial destruction of facilities;
E. riot; or
F. civil insurrection.

**Member Liability**

Except when certain Coinsurance, Copayments or other Limitations are specified this Member Handbook or the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS, you are not liable for any charges for Covered Services when these services have been provided or Referred by your Primary Care Physician and you are eligible for such benefits on the date of service.

**Limitation of the HMO’s Liability**

The HMO shall not be liable for injuries or damage resulting from acts or omissions of any officer or employee of the HMO or of any Provider or other person providing services or supplies to the Member; nor shall the HMO be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

**Right To Recover Payments Made In Error**

If the HMO should pay for any contractually excluded services through inadvertence or error, the HMO maintains the right to seek recovery of such payment from the Provider or Member to whom such payment was made.
Emergency, Urgent Care, Follow-Up Care

What Are Emergency Services?

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

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

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

Emergency Services Inside and Outside the Service Area

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

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

Medical Screening Evaluation

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

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

What is Urgent Care?

“Urgent Care” is Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that does not require Emergency Services. Urgent Care Covered Services are required in order to prevent a serious deterioration in the Member’s health if treatment were delayed. Examples of conditions requiring Urgent Care are: severe vomiting; severe eye pain with redness; and severe ear pain.
Urgent Care Inside the HMO’s Service Area

If you are within the Service Area and you need Urgent Care, call your Primary Care Physician first. If your Primary Care Physician is not in the office, leave a message requesting a return call. Your Primary Care Physician provides coverage 24 hours a day, 7 days a week for Urgent Care. Your Primary Care Physician, or the Physician covering for your Primary Care Physician, will arrange for appropriate treatment. Urgent Care provided within the Service Area will be covered only when provided or Referred by your Primary Care Physician.

What is Follow-Up Care?

“Follow-Up Care” is Medically Necessary follow-up visits that occur while you are outside the HMO’s Service Area. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while you are in the HMO’s Service Area. An example is Dialysis. Follow-Up Care must be Preapproved by your Primary Care Physician prior to traveling. This service is available for temporary absences (less than ninety (90) consecutive days) from the HMO’s Service Area.

Urgent Care and Follow-Up Care Outside Keystone’s Service Area – The BlueCard Program

Members have access to health care services when traveling outside of Keystone’s Service Area. These services are available through the Blue Cross and Blue Shield Association’s BlueCard Program. The length of time that you will be outside the Service Area may affect: (a) the benefits you receive; (b) your portion of cost-sharing; or (c) the procedures you must follow to obtain care covered under the Group’s Plan.

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

Urgent Care Benefits

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

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

- You call 1-800-810-BLUE. This number is available twenty-four (24) hours a day, seven (7) days a week. You will be given the names, addresses and phone numbers of three BlueCard Traditional Providers. The BlueCard Program has some international locations. When you call, you will be asked whether you are inside or outside of the United States.
- You decide which Provider you will visit.
- You call 1-800-227-3116 to get prior authorization for the service from Keystone.
With Keystone’s approval, you call the Provider to schedule an appointment. The BlueCard Traditional Provider confirms Member eligibility.

- You show your ID Card when seeking services from the BlueCard Traditional Provider.
- You pay the Copayment at the time of your visit.

**Follow-Up Care Benefits When Traveling Outside Keystone’s Service Area**

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

**Follow-Up Care required during a temporary absence (less than ninety (90) consecutive days) from Keystone’s Service Area will be covered when these steps are followed:**

- You are currently receiving urgent ongoing treatment for a condition.
- You plan to go out of Keystone’s Service Area temporarily, and your Primary Care Physician recommends that you continue treatment.
- Your Primary Care Physician must call 1-800-227-3116 to get prior authorization for the service from Keystone. If a BlueCard Traditional Provider has not been pre-selected for the Follow-Up Care, your Primary Care Physician or you will be told to call 1-800-810-BLUE.
- You or your Primary Care Physician will be given the names, addresses and phone numbers of three BlueCard Traditional Providers.
- Upon deciding which BlueCard Traditional Provider will be visited, you or your Primary Care Physician must inform Keystone by calling the number on the ID Card.
- You should call the BlueCard Traditional Provider to schedule an appointment.
- The BlueCard Traditional Provider confirms your eligibility.
- You show your ID Card when seeking services from the BlueCard Traditional Provider.
- You pay the Copayment at the time of your visit.
**Additional Information about the BlueCard Program**

When you obtain health care services through the BlueCard Program outside Keystone’s Service Area, the amount you pay for Covered Services is determined in one of two ways. Either:

(i) You pay the flat dollar amount (for example, a Specialty Care Physician Copayment) that you would pay if you were receiving the Covered Service in Keystone’s Service Area; or

(ii) The amount you pay, if based on a percentage of the Covered Service cost, is calculated on the lower of: (a) the billed charges for the Covered Service, or (b) the negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (“Host Blue”) passes on to us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of providers.

The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Covered Service or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in (ii) or require a surcharge, Keystone would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

**Continuing Care**

Medically Necessary care provided by any Provider other than your Primary Care Physician will be covered, subject to the **DESCRIPTION OF COVERED SERVICES, EXCLUSIONS - WHAT IS NOT COVERED**, and the **SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATION** sections, only until you can, without medically harmful consequences, be transferred to the care of your Primary Care Physician or a Referred Specialist designated by your Primary Care Physician.

All continuing care must be provided or Referred by your Primary Care Physician or coordinated through Member Services.
**Auto or Work-Related Accidents**

**Motor Vehicle Accident**

If you or a Dependent are injured in a motor vehicle accident, contact your Primary Care Physician as soon as possible.

**REMEMBER:** The HMO will always be secondary to your auto insurance coverage. However, in order for services to be covered by the HMO as secondary, your care must be provided or Referred by your Primary Care Physician.

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

Call Member Services as soon as possible and advise us that you have been involved in a motor vehicle accident. This information helps the HMO to coordinate your HMO Benefits with coverage provided through your auto insurance company. Only services provided or Referred by your Primary Care Physician will be covered by the HMO.

**Work-Related Accident**

Report any work-related injury to your employer and contact your Primary Care Physician as soon as possible.

**REMEMBER:** The HMO will always be secondary to your Worker’s Compensation coverage. However, in order for services to be covered by the HMO as secondary, your care must be provided or Referred by your Primary Care Physician.

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

Call Member Services as soon as possible and advise us that you have been involved in a work-related accident. This information helps the HMO to coordinate your HMO Benefits with coverage provided through your employer’s Worker’s Compensation coverage. Only services provided or Referred by your Primary Care Physician will be covered by the HMO.
Away From Home Care Program® Guest Membership Benefits

When Traveling Outside Keystone’s Service Area For Longer Periods - The Away From Home Care Program

Guest Membership Benefits

If you plan to travel outside Keystone’s Service Area for at least ninety (90) consecutive days, and you are traveling to an area where a Host HMO is located, you may be eligible to register as a Guest Member under the Away From Home Care Program for Guest Membership Benefits providing that the local Blue Cross Plan participates in the program. A thirty (30) day notification period is required before Guest Membership Benefits under the Away From Home Care Program become available. Guest Membership is available for a limited period of time. The Away From Home Care Coordinator will confirm the period for which you are registered as a Guest Member.

Who is Eligible to Register for Guest Membership Benefits?

You may register for Guest Membership Benefits when:

- You or your Dependents temporarily travel outside Keystone’s Service Area for at least ninety (90) days, but no more than one hundred eighty (180) days (long term traveler); or
- Your Dependent student is attending a school outside the Service Area for more than ninety (90) days (student); or
- Your Dependent lives apart from you and is outside the Service Area for more than ninety (90) days (families apart).

NOTE: You are required to contact the Away From Home Care Coordinator and apply for a Guest Membership by calling Member Services at the telephone number shown on the ID Card. Notification must be given at least thirty (30) days prior to your scheduled date of departure in order for Guest Membership Benefits to be activated.

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

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

NOTE: Because your Primary Care Physician can give advice and provide recommendations about health care services that you may need while traveling, you are encouraged to receive routine or planned care prior to leaving home.
As a Guest Member, you must select a Primary Care Physician from the Host HMO’s Primary Care Physician network. In order to receive Guest Membership Benefits, the Primary Care Physician in the Host HMO Service Area must provide or arrange for all of your Covered Services while you are a Guest Member. Neither Keystone nor the Host HMO will cover services you receive as a Guest Member that are not provided or arranged by the Primary Care Physician in the Host HMO Service Area and Preapproved by the Host HMO. Registration in the Away From Home Care Program is available only through contracting HMOs in the Blue Cross and Blue Shield Association’s HMO network. Information regarding the availability of Guest Membership Benefits may be obtained from the Away From Home Care Coordinator by calling Member Services at the telephone number shown on the ID Card.

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

**When You Don’t Use the BlueCard or Guest Membership Programs**

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

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

**NOTE:** It is your responsibility to forward to Keystone any bill you receive for Emergency Services or out-of-area Urgent Care provided by a Non-Participating Provider.
Eligibility, Change and Termination Rules Under the Plan

Eligible Subscriber

A. An eligible Subscriber is an individual who is listed on the completed Enrollment/Change Form provided by the HMO and:
   (1) Who resides or, with approval from the HMO, works in the Service Area; and
   (2) Who is an active Employee whose normal work week is defined by the Group; and
   (3) Who is entitled to participate in the Group’s health benefits program, including compliance with any probationary or waiting period established by the Group or who is entitled to coverage under a trust agreement or employment contract; and
   (4) For whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling.

B. Subscribers who work but do not reside in the HMO Service Area must sign a Member Statement of Understanding recognizing that the Benefits provided by the HMO are only available within the Service Area, except as otherwise stated in this Member Handbook.

Eligible Dependent

A. An eligible Dependent is an individual for whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling; who resides in the Service Area, unless otherwise provided in this section; who meets all the eligibility requirements established by the Group; who is listed on the Enrollment/Change Form completed by the Subscriber; and who is:
   (1) The Subscriber’s legal spouse, if applicable; or
   (2) An unmarried child (including stepchild, legally adopted child, child placed for adoption, or natural child) of either the Subscriber or the Subscriber’s spouse, who is within the Limiting Age for Dependents as set forth in this Member Handbook, or a child for whom the Subscriber is legally required to provide health care coverage; or
   (3) An unmarried child for whom the Subscriber or the Subscriber’s spouse is a court appointed legal guardian; or
   (4) An unmarried child, regardless of age, who, in the judgment of the HMO, is incapable of self-support due to a mental or physical handicap which commenced prior to the child’s reaching the Limiting Age for Dependents under this Member Handbook and for which continuing justification may be required by the HMO; or
   (5) An unmarried child within the Limiting Age for Dependents under this Member Handbook who resides in the Service Area and is a full-time student in an Accredited Educational Institution for which continuing justification is required; or
(6) An unmarried child who is past the Limiting Age for Dependents will be eligible when they: (1) are a full-time student; (2) are eligible for coverage under this Contract; and (3) prior to attaining the Limiting Age for Dependents and while a full-time student, were (a) a member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and were called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or (b) a member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

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

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

(7) A Dependent of a Subscriber who is enrolled in a HMO Medicare risk program. A Dependent child of such Subscriber must be within the Limiting Age for Dependents under this Member Handbook; or

(8) The newborn child of a Member for the first thirty-one (31) days immediately following birth. Coverage will continue in effect thereafter if the newborn qualifies as a Dependent, is enrolled by the Subscriber within thirty-one (31) days of birth, and any appropriate payment due, calculated from the date of birth, is received by the HMO.

Under this Member Handbook no other Benefits, except conversion privileges, will be extended to the newborn child of a Dependent unless such newborn child meets the eligibility requirements of a Dependent set forth in this section and is enrolled as a Dependent within thirty-one (31) days of eligibility.

**When to Notify the HMO of a Change**

Certain changes in your life may affect your HMO coverage. Please notify us of any changes through the benefits office of your Group benefits administrator. To help us effectively administer your health care benefits, the HMO should be notified of the following changes within thirty (30) days: name; address; status or number of Dependents; marital status; or eligibility for Medicare coverage, or any other changes in eligibility.

**Open Enrollment**

Your Group benefits administrator will have an open enrollment period at least once a year, and will notify you of the time. At this time, you may add eligible Dependents to your coverage.
**Special Enrollment**

A person in the Group or a Subscriber’s Dependent who was previously eligible for coverage under the HMO, but did not enroll during an initial enrollment period, and who meets the following conditions will be allowed to enroll during a Special Enrollment period:

A. The person in the group or a Subscriber’s Dependent declined this coverage initially due to other health coverage, and notified the HMO in writing;

B. The other health coverage was:

1. COBRA continuation coverage which exhausted; or

2. Terminated as a result of loss of eligibility for that coverage due to:
   a. legal separation, divorce, death, termination of employment; or
   b. reduction in the number of hours of employment; or
   c. the employer ceasing contributions towards such coverage; or
   d. the termination of the program option in which the individual is enrolled; or
   e. the individual is enrolled in a health maintenance organization plan and the individual no longer resides, lives, or works in that health maintenance organization’s service area; or
   f. if the individual is enrolled in coverage that is subject to a lifetime benefit limit, the individual incurring a claim that would meet or exceed the lifetime limit; and

C. Enrollment is requested under the HMO no later than 30 days after the date the coverage described in B. 1. or 2. above terminated.

If a person becomes a Dependent of a Subscriber through marriage, birth, or adoption or placement for adoption, he or she may be enrolled under this special enrollment provision no later than 30 days after the date he or she is eligible for coverage.

Coverage for the Subscriber or the Subscriber’s Dependent under this provision takes effect no later than:

A. The first day of the month beginning after the date the completed request for enrollment is received by the HMO; or

B. The date of birth or the date of adoption or placement for adoption if the Dependent is a newborn or adopted child; or

C. In the case of marriage, the first day of the first calendar month beginning after the date the completed request is received.

**Newly Hired**

Within 30 days of becoming eligible for your new Group’s health coverage, you may join the HMO. You must add existing eligible Dependents to your coverage at this time or wait until the next open enrollment period.
Late Enrollment

If you or your Dependent did not request enrollment for coverage with the HMO during the initial enrollment period or in a Special Enrollment period, or your newly eligible Dependent failed to qualify for special enrollment and did not enroll within 30 days of the date during which the individual was first eligible to enroll under the HMO, you may apply for coverage as a Late Enrollee.

Marriage

You may add your spouse to your coverage within 30 days of your marriage. Coverage for your spouse will be effective on the date of your marriage.

New Child

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

In situations where the newborn’s father is the HMO Member but the mother is not a Member, Member Services must be notified prior to the mother’s hospitalization for delivery.

Court-Ordered Dependent Coverage

If you are required by a court order to provide health care coverage for your eligible Dependent, your Dependent will be enrolled within thirty (30) days from the date the HMO receives notification and a copy of the court order.

REMEMBER: You must notify the HMO of any changes to Dependent coverage within thirty (30) days of the change in order to ensure coverage for all eligible family members. Notifications to the HMO should be through the benefits office of your Group benefits administrator.

Termination of Coverage

The HMO may cancel your coverage under the following conditions:

A. If you commit material misrepresentation or fraud in applying for or obtaining coverage from the HMO (subject to your rights under the MEMBER COMPLAINT APPEAL AND GRIEVANCE APPEAL PROCESS);

B. If you misuse your ID Card, or allow someone other than your eligible Dependents to use a ID Card to receive care or benefits;

C. If you cease to meet the eligibility requirements;

D. Your Group terminates coverage with the HMO;
E. If you display a pattern of non-compliance with your Physician’s Plan of Treatment. You will receive written notice at least thirty (30) days prior to termination. You have the right to utilize the MEMBER COMPLAINT APPEAL AND GRIEVANCE APPEAL PROCESS; or

F. If you do not cooperate with the HMO in obtaining information necessary to determine the HMO’s liability under this program.

Inpatient Provision upon Termination of Coverage

If you are receiving Inpatient Care in a Hospital or Skilled Nursing Facility on the day this coverage is terminated by the HMO, except for termination due to fraud or material misrepresentation, the Benefits shall be provided until the earliest of:

A. The expiration of such Benefits according to the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS included with this Handbook.

B. Determination of the Primary Care Physician and the HMO that Inpatient Care is no longer Medically Necessary; or

C. Your discharge from the facility.

NOTE: The HMO will not terminate your coverage because of your health status, your need for Medically Necessary Covered Services or your having exercised rights under the Complaint Appeal and Grievance Appeal Process.

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

Continuation

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), under certain circumstances your employer may be required to offer you the option of temporary continuation of your coverage, when it would otherwise end. The events that would qualify you or your covered family Members for this continued coverage include:

- The death of the Subscriber;
- Termination of employment (except for gross misconduct);
- Divorce or legal separation;
- Loss of Dependent status;
- A reduction in the number of hours worked.

The continued coverage must be the same as that offered under the Group health plan, and it may be continued for 18 to 36 months, depending on the situation. The provision for COBRA Continuation of Coverage will not apply if the Group ceases to maintain coverage for its members or if the Group is not obligated under federal laws/regulations to provide COBRA coverage/benefits. If you would like more details on eligibility, please consult your benefits office.

Conversion

If you or your Dependents become ineligible for coverage through your Group plan, you may apply for continuation of the HMO coverage in an appropriate non-group program. You must reside in the HMO’s five (5) county area in order to be eligible for the non-group HMO program. The five (5) county area includes: Bucks, Chester, Delaware, Montgomery and Philadelphia counties. If you do not live in the HMO’s five (5) county area, enrollment in the HMO’s non-group program is provided to you and your Dependents for ninety (90) days from the date your Group coverage ends. After this time period, you and your Dependents will have to convert to another plan. You and your Dependents may convert to the local Blue Cross®/Blue Shield® plan for the area in which you live.

Your application for this conversion coverage must be made to the HMO within thirty (30) days of when you become ineligible for Group coverage. The Benefits provided under the available non-group program may not be identical to the Benefits under your Group plan.

The conversion privilege is available to you and:

A. Your surviving Dependents, in the event of your death;
B. Your spouse, in the event of divorce; or
C. Your child who has reached the Limiting Age For Dependents.

The Dependent must reside in the HMO’s five (5) county area in order to be eligible for the non-group HMO program.
This conversion privilege is not available if you are terminated by the HMO for cause (such as deliberate misuse of an ID Card, significant misrepresentation of information that is given to the HMO or a Provider, or fraud).

If you need more information regarding your conversion privilege, please call Member Services at the telephone number shown on the ID Card. Should you choose continued coverage under COBRA (see above), you become eligible to convert to an individual, non-group plan at the end of your COBRA coverage.
Your Membership Rights and Responsibilities

If you have questions, suggestions, problems, or concerns regarding benefits or services rendered, the HMO is ready to assist you. Don’t hesitate to call Member Services at the telephone number shown on the ID Card. Our Representatives will respond to any inquiry promptly.

Member Rights

The HMO and the Participating Providers honor the following rights of all Members:

- The Member has the right to information about the health plan, its benefits, policies, participating practitioners/Providers and Members’ rights and responsibilities. Written information that is provided to the Member will be readable and easily understood.
- The Member has the right to be treated with respect, and recognition of their dignity and right to privacy.
- The Member has the right to participate in decision making regarding his/her health care. This right includes candid discussions of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage.
- The Member has a right to voice Complaints or appeals about the health plan or care provided, and to receive a timely response.
- The Member has the right to make recommendations regarding the organization’s Member rights and responsibilities policies by contacting the Member Services Department in writing.
- The Member has the right to choose practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners.
- The Member has the right to confidential treatment of medical information. The Member also has the right to have access to his/her medical record in accordance with applicable state and federal law.
- The Member has the right to reasonable access to medical services.
- The Member has the right to receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, sexual orientation, national origin or source of payment.
- The Member has the right to formulate advance directives. The plan will provide information concerning advance directives to Members and practitioners and will support Members through its medical record keeping policies.
Member Responsibilities

In support of a person’s rights as a Member and to help the Member participate fully in the health plan, HMO Members have certain responsibilities:

- Members have the responsibility to communicate, to the extent possible, information the plans, participating practitioners and Providers need in order to care for the Member.
- Members have the responsibility to follow the plans and instructions for care that they have agreed on with their practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Members have the responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Members have the responsibility to review all benefit and membership materials carefully and to follow the regulations pertaining to the health plan.
- Members have the responsibility to ask questions to assure understanding of the explanations and instructions given.
- Members have the responsibility to treat others with the same respect and courtesy expected for oneself.
- Members have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.
- Members may be financially responsible for the cost of any service or supply received after the date the Member’s coverage is terminated under this Group Contract.
Coordination of Benefits

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

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

Coordination of Benefits Administration

A. If another plan under which you have coverage does not have a COB provision, that plan will be primary and the HMO will be secondary. In order for services to be covered by the HMO as secondary, your care must be provided or Referred by your Primary Care Physician.
B. For those plans which have COB clauses, the following provisions apply:
   (1) The plan which covers a Member as a Subscriber (meaning not a dependent) will be primary. The plan which covers the Member as dependent will be secondary;
   (2) If there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan;
   (3) Where both plans cover a child as a dependent, the plan of the parent whose date of birth (excluding year) occurs earlier in the calendar year will be primary (the Birthday Rule). If both parents have the same birthday, the plan covering the parent longer will be primary;
   (4) If parents are separated or divorced, and no court decree applies, the benefits for the child will be determined as follows:
      a. The plan of the parent with custody of the child will be primary;
      b. The plan of the spouse of the parent with custody of the child will be secondary;
      c. The plan of the parent not having custody of the child will be third;
      d. In cases of joint custody, benefits will be determined by paragraph B.(3) above, the Birthday Rule.
Subrogation

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

General Information About Member Appeal Processes

The HMO maintains a Complaint appeal process and a Grievance appeal process for its Members. Each of these appeal processes provides formal review for a Member’s dissatisfaction with a denial of coverage or other issues related to his/her health plan underwritten by the HMO.

The Complaint appeal process and the Grievance appeal process focus on different issues and have other differences. Please refer to the separate sections below entitled “Member Complaint Appeal Process” and “Member Grievance Appeal Process” for specific information on each process.

However, the Complaint appeal process and Grievance appeal process also have some common features. To understand how to pursue a Member appeal, you should also review the background information outlined here that applies to both the Complaint appeal process and the Grievance appeal process.

• Authorizing Someone To Represent You. At any time, you may choose a third party to be your representative in your Member appeal such as a Provider, lawyer, relative, friend, another individual, or a person who is part of an organization. The law states that your written authorization or consent is required in order for this third party—called an “Appeal Representative” or "Authorized Representative”—to pursue an appeal on your behalf. An Appeal Representative may make all decisions regarding your appeal, provide and obtain correspondence, and authorize the release of medical records and any other information related to your appeal. In addition, if you choose to authorize an Appeal Representative, you have the right to limit their authority to release and receive your medical records or in any other way you identify.

In order to authorize someone else to be your Appeal Representative, you must complete valid authorization forms. The required forms are sent to adult Members or the parents, guardians or other legal representatives of minor or incompetent Members who appeal and indicate that they want an Appeal Representative. Authorization forms can be obtained by calling or writing to the address listed below:

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

Except in the case of an Expedited appeal, the HMO must receive completed, valid authorization forms before your appeal can be processed. (For information on Expedited appeals, see the definition below and the references in the “Member Complaint Appeal Process” and “Member Grievance Appeal Process” sections below.) You have the right to withdraw or rescind authorization of an Appeal Representative at any time during the process.

If your Provider files an appeal on your behalf, the HMO will verify that the Provider is acting as your Appeal Representative with your permission by obtaining valid authorization forms. A Member who authorizes the filing of an appeal by a Provider cannot file a separate appeal.
• **How to File and Get Assistance.** Appeals may be submitted either verbally or in writing by you or your Appeal Representative with your authorization by following the steps outlined below in the descriptions of the “Member Complaint Appeal Process” and “Member Grievance Appeal Process.” At any time during these appeal processes, you may request the help of a HMO employee in preparing or presenting your appeal; this assistance will be available at no charge. Please note that a HMO employee designated to assist you will not have participated in the previous decision to deny coverage for the issue in dispute and will not be a subordinate of the original reviewer.

• **Providing and Obtaining Information.** At all appeal levels, you or your Appeal Representative may submit additional information pertaining to your case. You may also specify the remedy or corrective action being sought. The HMO will provide, at any time during the appeal process, access to, and copies of all documents, records, and other information reviewed by the Committee deciding the appeal that is not confidential, proprietary or privileged, as well as the resulting decision.

• **Appeal Decision Letters.** If your appeal request is not granted in full, the decision letter will state the reasons for the determination and describe how to pursue any available options for further appeal review. If a Benefit provision, internal rule, guideline, protocol, or other similar criterion was used in making the determination, it will either be stated or there will be instructions on how to receive this information at no charge. The decision letter will also state the qualifications of the individual(s) who reviewed your appeal—by title, a general description of experience, and the board certification of any Physician-reviewer—and indicate their understanding of the nature of the appeal. You may request, at no charge, the name(s) of the individual(s) who participated in the decision.

• **Appeal Classifications.** The two classifications of appeals—Complaints and Grievances—established by Pennsylvania state laws and regulations are described in detail in separate sections below. A Grievance appeal may be filed when the denial of a Covered Service is based primarily on Medical Necessity. A Complaint appeal may be filed to challenge a denial based on a Contract Limitation or to complain about other aspects of health plan policies or operations. You may question the classification of your appeal as a Complaint or Grievance by contacting the HMO’s Member Appeals Department or your assigned appeals specialist at the address and telephone number shown above or the Pennsylvania Department of Health as follows:

  Department of Health  
  Bureau of Managed Care  
  Health and Welfare Building  
  Room 912  
  7th and Forster Streets  
  Harrisburg, PA 17120  
  Toll Free 1-888-466-2787 or 1-717-787-5193  
  Fax 1-717-705-0947
Appeals are also subject to the following classifications that affect the time available to conduct the appeal review:

A **Pre-service** appeal is any appeal for Benefits with a coverage requirement that Preapproval or Precertification by the HMO must be obtained before Medical Care and services are received. A maximum of **fifteen (15) days** is available for each of the two (2) levels of internal review available for a standard Pre-service appeal.

A **Post-service** appeal includes any appeal for Benefits for Medical Care or services that a Member has already received. A maximum of **thirty (30) days** is available for each of the two (2) levels of internal review available for a standard Post-service appeal.

An Urgent Care or ** Expedited** appeal is an appeal that occurs upon the request of the Member’s Physician certifying, and/or when the HMO determines, that a delay in decision-making based on standard appeal timeframes could seriously jeopardize the Member’s life, health, or ability to regain maximum function or subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision. A maximum of **forty-eight (48) hours** is available for internal review of an Expedited appeal.

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

- **Changes in Member Appeals Processes.** Please note that Member appeal processes may change due to changes in the applicable state and federal laws and regulations, accreditation standards, and/or to improve the Member appeals processes.

**Member Complaint Appeal Process**

**Informal Member Complaint Process**

The HMO will make every attempt to answer any questions or resolve any concerns you have related to Benefits or services.

If you have a concern, you should call Member Services at the telephone number listed on your ID card, or write to:

Manager of Member Services  
Keystone Health Plan East  
P.O. Box 8339  
Philadelphia, PA 19101-8339

Most Member concerns are resolved informally at this stage. If the HMO cannot immediately resolve your concern, we will acknowledge it in writing within **five (5) business days** of receiving it. If you are not satisfied with the response to your concern from the HMO, you have the right to file a formal Complaint appeal within **one hundred eighty (180) calendar days**, through the “ Formal Member Complaint Appeal Process” described below.
**Formal Member Complaint Appeal Process**

The HMO’s Members may file a formal Complaint appeal regarding an unresolved dispute or objection regarding coverage, including Contract exclusions and non-Covered Services, Participating or Non-Participating Provider status, or the operations or management policies of The HMO. The Complaint appeal process consists of two (2) internal levels of review by The HMO, and one external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department. There is also an internal expedited Complaint appeal process in the event your condition involves an issue that may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed, as determined and validated by your Physician, if reviewed in standard Pre-service appeal timeframes. Remember, no legal action can usually be taken until all of the Complaint appeal processes have been followed.

**Internal Complaint Appeals**

**Internal First Level Standard Complaint Appeals**

You may file a formal, first level standard Complaint appeal within **one hundred eighty (180) calendar days** from either your receipt of the original notice of denial from The HMO or completion of the “Informal Member Complaint Appeal Process” described above. To file a first level standard Complaint appeal, call Member Services toll free at the telephone number listed on your ID card, or call, write or fax the Member Appeals Department as follows:

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

The HMO will acknowledge receipt of your Complaint appeal in writing.

The First Level Complaint Committee will complete its review of your standard Complaint appeal within:  
(1) **fifteen (15) calendar days** from receipt of a Pre-service appeal; and, (2) thirty (30) calendar days from receipt of a Post-service appeal. A Pre-service Complaint includes any appeal for Benefits for which Preapproval is required prior to receiving coverage for Medical Care. A Post-service Complaint appeal includes any appeal for Benefits for care or services that you have already received.

The First Level Complaint Committee is composed of one (1) or more of the HMO employees who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. You will be sent their decision in writing within the timeframes noted above. If your Complaint appeal is denied, the decision letter states: (1) the specific reason for the decision; (2) the plan provision on which the decision is made and instructions on how to access the provision; and, (3) how to appeal to the next level if you are not satisfied with the decision.
Internal Second Level Standard Complaint Appeals

If you are not satisfied with the decision from your first level standard Complaint, you may file a second level standard Complaint to the Second Level Complaint Committee within sixty (60) calendar days of your receipt of the First Level Complaint Committee’s decision from The HMO. To file a second level standard Complaint, call, write or fax the Member Appeals Department at the address and telephone numbers listed above.

You have the right to present your Complaint appeal to the Committee in person or by way of a conference call. Your appeal can also be presented by your Provider or another Appeal Representative if your authorization is obtained. (See “General Information About Member Appeal Processes” above for information about authorizations.) The HMO will attempt to contact you to schedule the Second Level Complaint Committee meeting for your standard Complaint appeal.

Upon receipt of your appeal, you will be notified in writing when possible fifteen (15) calendar days in advance of a date and time scheduled for the Second Level Complaint Committee’s meeting. You may request a change in the meeting schedule. We will do our best to accommodate your request while remaining within the established timeframes. If you do not participate in the meeting, the Second Level Complaint Committee will review your Complaint appeal and make its decision based on all available information.

The Second Level Complaint Committee meets and renders a decision on your standard Complaint appeal within:

(1) **fifteen (15) calendar days** from receipt of a Pre-service appeal; and, (2) thirty (30) calendar days from receipt of a Post-service appeal.

The Second Level Complaint Committee is composed of at least three (3) persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Second Level Complaint Committee members will include the HMO’s staff, with one third of the Committee being Members or other persons who are not employed by the HMO. You may submit supporting materials both before and at the appeal meeting. Additionally, you have the right to review all information considered by the Committee that is not confidential, proprietary or privileged.

The Second Level Complaint Committee meeting is a forum where Members have an opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany you unless you receive prior approval from the HMO for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as your Appeal Representative or to provide general, personal assistance. Members, Appeal Representatives and others assisting the Member may not audiotape or videotape the Committee proceedings.

You will be sent the decision letter of the Second Level Complaint Committee on your standard Complaint appeal within the timeframes noted above. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or Department of Health as described in the decision letter. (See also “External Complaint Appeals” below.)
Internal Expedited Complaint Appeals

If your case involves an issue that may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed, as determined and validated by your Physician, if reviewed in standard Pre-service appeal timeframes, then you or your Physician may ask to have your case reviewed in a faster manner, as an internal Expedited Complaint. There is only one internal level of appeal review for an expedited Complaint appeal.

To request an internal Expedited Complaint by the HMO, call Member Services at the toll free telephone number listed on your ID card, or call or fax the Member Appeals Department at the address or telephone numbers listed above. The HMO will promptly inform you whether your appeal request qualifies for Expedited review or instead will be processed as a standard Complaint appeal. The Expedited Complaint Committee has the same composition as a Second Level Complaint Committee for a standard Complaint appeal—at least three (3) persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Committee members include the HMO’s staff, with one third of the Committee being Members or other persons who are not employed by the HMO.

You have the right to present your Expedited Complaint to the Committee in person or by way of a conference call. Your appeal can also be presented by your Provider or another Appeal Representative if your authorization is obtained. (See “General Information About Member Appeal Processes” above for information about authorizations.) If you do not participate in the meeting, the Expedited Complaint Committee will review your Complaint appeal and make its decision based on all available information.

The Expedited Complaint Committee meeting is a forum where Members have an opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany you unless you receive prior approval from the HMO for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as your Appeal Representative or to provide general, personal assistance. Members, Appeal Representatives and others assisting the Member may not audiotape or videotape the Committee proceedings.

The expedited Complaint appeal review is completed within forty-eight (48) hours after the HMO receives your request for an expedited Complaint appeal. During this time you will be notified by telephone of the decision and a decision letter will be sent to you. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or the Pennsylvania Department of Health as described in the decision letter. (See also, “External Complaint Appeals” below.)
**External Complaint Appeals**

**External Standard and Expedited Complaint Appeals**

If you are not satisfied with the decision of the internal Second Level Complaint Committee or Expedited Complaint Committee, you have the right to an external appeal. Your external Complaint appeal is to be filed within **fifteen (15) calendar days** of your receipt of the decision letter for a second level standard Complaint appeal and within **two business days** of your receipt of the decision letter for an expedited Complaint appeal. Your request for external Complaint appeal review is to be filed in writing to the Pennsylvania Insurance Department (PID) or Pennsylvania Department of Health (DOH) at the addresses noted below:

<table>
<thead>
<tr>
<th>Pennsylvania Insurance Department</th>
<th>Department of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bureau of Consumer Services</td>
<td>Bureau of Managed Care</td>
</tr>
<tr>
<td>1321 Strawberry Square</td>
<td>Health and Welfare Building</td>
</tr>
<tr>
<td>Harrisburg, PA 17120</td>
<td>Room 912</td>
</tr>
<tr>
<td>Toll Free 1-877-881-6388</td>
<td>7th and Forster Streets</td>
</tr>
<tr>
<td>1-717-787-2317</td>
<td>Harrisburg, PA 17120</td>
</tr>
<tr>
<td>Fax 1-717-787-8585</td>
<td>Toll Free 1-888-466-2787</td>
</tr>
<tr>
<td></td>
<td>1-717-787-5193</td>
</tr>
<tr>
<td></td>
<td>Fax 1-717-705-0947</td>
</tr>
</tbody>
</table>

Your request for external review of your standard or expedited Complaint appeal should include your name, address, daytime telephone number, the name of the HMO as your managed care plan, the group number, your HMO ID number and a brief description of the issue being appealed. Also include a copy of your original request for an internal second level standard or expedited Complaint appeal review to the HMO and copies of any correspondence and decision letters from the HMO.

When an external standard or expedited Complaint appeal request is submitted to the PID or DOH, the original submission date of the request is considered the date of receipt. The regulatory agency that receives the request will review it and transfer it to the other agency if this is found to be appropriate. The regulatory agency that handles your external Complaint appeal will provide you and the HMO with a copy of the final determination of its decision.

**Member Grievance Appeal Process**

**Formal Member Grievance Appeal Process for Decisions Based on Medical Necessity**

The HMO’s Members may file a formal Grievance appeal of a decision by the HMO regarding a Covered Service that was denied or limited based primarily on Medical Necessity, the cosmetic or experimental/investigative exclusions, or other grounds that rely on a medical or clinical judgment. The Grievance appeal process consists of two (2) internal Grievance reviews by the HMO—a first level standard Grievance and second level standard Grievance—and an external review through an external certified review entity or utilization review agency assigned by the Pennsylvania Department of Health (DOH).
There is also an internal and external expedited Grievance appeal process in the event your condition involves an issue that may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed, as determined and validated by your Physician if reviewed in standard Pre-service appeal timeframes. Remember, no legal action can usually be taken until all of the Grievance appeal processes have been followed.

**Internal Grievance Appeals**

**Internal First Level Standard Grievance Appeals**

You may file a first level standard Grievance appeal within **one hundred eighty (180) calendar days** from the date of receipt of the original denial by the HMO. To do so, call Member Services at the toll free telephone number listed on your ID Card, or call, write or fax the Member Appeals Department as follows:

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

The HMO will acknowledge receipt of your Grievance appeal in writing.

Your first level standard Grievance appeal is reviewed by a Committee for which a plan Medical Director is the decision-maker. The decision-maker is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist or “same or similar specialty Physician” is a licensed Physician or Psychologist who: (1) is in the same or similar specialty as typically manages the care under review; (2) has had no previous involvement in the case; and, (3) is not a subordinate of the person who made the original determination. The matched specialist must also hold an active license to practice medicine and be board certified.

If the matched specialist Physician is a consultant, his or her opinion on the Grievance appeal issues will be reported to the HMO in writing for consideration by the Committee. You may request a copy of the matched specialist’s opinion in writing, and when possible it will be provided to you **at least seven (7) calendar days** prior to the date of review by the First Level Grievance Committee. The matched specialist’s report includes his or her credentials as a licensed Physician or Psychologist such as board certification. If the matched specialist is attending the meeting, a copy of his/her credentials will be provided to you.

The First Level Grievance Committee completes its review of your standard Grievance appeal within: (1) **fifteen (15) calendar days** from receipt of a Pre-service appeal; and, (2) **thirty (30) calendar days** from receipt of a Post-service appeal. A Pre-service Grievance appeal includes any appeal for Benefits for which Preapproval is required prior to receiving Medical Care. A Post-service Grievance appeal is any appeal for Benefits for care or services that you have already received.

You will be sent the Committee’s decision on your first level standard Grievance appeal in writing within the timeframes noted above. If your Grievance appeal is denied, the decision letter states: (1) the specific reason for the denial; (2) the plan provision on which the decision is made and instructions on how to access the provision; and, (3) how to appeal to the next level if you are not satisfied with the decision.
Internal Second Level Standard Grievance:

If not satisfied with the decision from your first level standard Grievance, you may file a second level standard Grievance appeal within sixty (60) calendar days of your receipt of the first level standard Grievance appeal decision from the HMO. To file a second level standard Grievance, call, write or fax the Member Appeals Department at the address and numbers listed above.

You have the right to present your Grievance appeal to the Committee in person or by way of a conference call. Your appeal can also be presented by your Provider or another Appeal Representative if your authorization is obtained. (See “General Information About Member Appeal Processes” above for information about authorizations.)

The Second Level Grievance Committee for a standard Grievance appeal is composed of at least three (3) persons who have had no previous involvement with your case and who are not subordinate to the original reviewer. The Second Level Grievance Committee members include the HMO’s staff. At least one of these Committee members is a plan Medical Director, a Physician who holds an active license and is board certified.

Upon receipt of your appeal, you will be notified in writing when possible fifteen (15) calendar days in advance of a date and time scheduled for the Second Level Grievance Committee’s meeting. You may request a change in the meeting schedule. The HMO will try to accommodate your request while remaining within the established timeframes. If you do not participate in the meeting, the Second Level Grievance Committee will review your Grievance appeal and make its decision based on all available information.

The Second Level Grievance Committee will meet and render a decision on your standard Grievance appeal within: (1) fifteen (15) calendar days from receipt of a Pre-service appeal; and, (2) thirty (30) calendar days from receipt of a Post-service appeal.

The Committee’s review will include the matched specialist report. Upon written request, you will be provided with a copy of this report when possible within at least seven (7) calendar days prior to the review by the Second Level Grievance Committee. The matched specialist’s report includes his or her credentials as a licensed Physician or Psychologist such as board certification. If the matched specialist is attending the meeting, his/her credentials such as board certification will be provided to you. You may submit supporting materials both before and at the time of the appeal meeting. Additionally, you have the right to review all information considered by the Committee that is not confidential, proprietary or privileged.

The Second Level Grievance Committee meetings are a forum where Members each have the opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany you, unless you receive prior approval from the HMO for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member’s Appeal Representative or to provide general, personal assistance. Members may not audiotape or videotape the Committee proceedings.

You will be sent the decision of the Second Level Grievance Committee in writing within the timeframes noted above. The decision is final unless you choose to file an external standard Grievance within fifteen (15) calendar days of your receipt of the decision notice from the HMO.
**Internal Expedited Grievance Appeals**

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed, as determined and validated by your Physician, if reviewed in standard Pre-service appeal timeframes, then you or your Physician may ask to have your case reviewed in a faster manner, as an expedited Grievance. There is only one internal level of appeal review for an expedited Grievance appeal.

To request an internal Expedited Grievance review by the HMO, call Member Services at the toll free telephone number listed on your ID card, or call, or fax the Member Appeals Department at the telephone numbers listed above. The HMO will promptly inform you whether your appeal request qualifies for expedited review or instead will be processed as a standard Grievance appeal.

The Expedited Grievance Committee has the same composition as a Second Level Grievance Committee for a standard Grievance appeal—at least three (3) persons who have had no previous involvement with your case and who are not subordinates of the person who made the original determination. The Committee members include the HMO’s staff.

You have the right to present your Expedited Grievance to the Committee in person or by way of a conference call. Your appeal can also be presented by your Provider or another Appeal Representative if your authorization is obtained. (See “General Information About Member Appeal Processes” above for information about authorizations.) If you do not participate in the meeting, the Expedited Grievance Committee will review your Grievance appeal and make its decision based on all available information.

The Expedited Grievance Committee meeting is a forum where Members have an opportunity to present their issues in an informal setting that is not open to the public. Two other persons may accompany you unless you receive prior approval from the HMO for additional assistance due to special circumstances. Members of the press may only participate in their personal capacity as your Appeal Representative or to provide general, personal assistance. Members, Appeal Representatives and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Expedited Grievance review is completed promptly based on your health condition. Within **forty-eight (48) hours** of receipt of your internal Expedited Grievance, the HMO will notify you by telephone, as well as in writing of the decision. If not satisfied with the decision from the HMO, you may file an external expedited Grievance appeal as described below.

**External Grievance Appeals**

The two types of external Grievance appeals—standard and Expedited—are described below. Members are not required to pay any of the costs associated with the external standard or expedited Grievance appeal review. However, when a Provider is a Member’s Appeal Representative for external Grievance appeal review, then the Provider is required to: (1) place in escrow one-half of the estimated costs of the external Grievance appeal process; and, (2) pay the full costs for the external process if the Provider’s appeal on behalf of the Member is not successful.
An independent certified review entity (CRE) assigned by the Pennsylvania Department of Health (DOH) reviews an external Grievance appeal. For standard and expedited Grievance appeals, the HMO authorizes the service(s) or pays claims, if the CRE decides that the requested care or services are Covered Services that are Medically Necessary. You are notified in writing of the time and procedure for claim payment or approval of the service(s) in the event that the CRE overturns the prior appeal decision. The CRE’s decision may be appealed to a court of competent jurisdiction within **sixty (60) calendar days**.

**External Standard Grievance Appeals**

You have **fifteen (15) calendar days** from the receipt of the decision letter for a second level standard Grievance to request an external standard Grievance appeal review. To file a request an external standard Grievance review by a DOH-assigned CRE, contact the Member Appeals Department as directed in the second level Grievance appeal decision letter or as follows:

Member Appeals Department  
PO. Box 41820  
Philadelphia, PA 19101-1820  
Toll Free: 1-888-671-5276  
Fax: 1-888-671-5274

You will be sent written acknowledgement that the HMO has received your external standard Grievance request from the HMO within **five (5) business days** of its receipt of your request. The HMO contacts the DOH to request assignment of a CRE to review your Grievance. The HMO notifies you of the name, address and telephone number of the CRE assigned by the DOH to your Grievance within **two (2) business days** of the HMO’s receipt of the assignment from the Department. You and the HMO have **seven (7) business days** to notify the DOH, if there is an objection to the assignment of the CRE on the basis of conflict of interest.

To submit additional information, you or your Appeal Representative should send it to the HMO at the address appearing above and to the CRE within **fifteen (15) calendar days** of your receipt of the HMO’s letter acknowledging your external standard Grievance appeal request. The HMO forwards copies of the information used in reviewing your internal Grievance appeal to the CRE and a list of those documents to you or your Appeal Representative within **fifteen (15) calendar days** of its receipt of your external standard Grievance review appeal.

The CRE will send you or your Appeal Representative a written decision within **sixty (60) calendar days** of the date when you filed your request for an external review. The CRE issues its decision and follow-up occurs as described above in the introduction to this section.

**External Expedited Grievance Appeals**

You have **two (2) business days** from your receipt of the internal expedited Grievance appeal decision to contact the HMO at the telephone number and address listed above to request an external expedited Grievance appeal. The HMO forwards your request to the DOH within **24 hours**, which assigns a CRE within twenty-four (24) hours. The HMO forwards a copy of the internal Grievance appeal case file to the CRE on the next business day and the CRE issues a decision **within two (2) business days** of receipt. The CRE issues its decision and follow-up occurs as described above in the introduction to this section.
Additional Information About How We Reimburse Providers

Our HMO reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for our Members. Set forth below is a general description of our HMO reimbursement programs, by type of participating health care provider. These programs vary by state. Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If after reading this material you have any questions about how your health care provider is compensated, please speak with them directly or contact us.

Professional Providers

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

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

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

Institutional Providers

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

For most outpatient and Emergency Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient Covered Services (e.g., lab and radiology) that includes both the facility and Physician payment. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various Covered Services.
Some Hospitals participate in a quality incentive program. The program provides increased reimbursement to these Hospitals when they meet specific quality and other criteria, including “Patient Safety Measures.” Such patient safety measures are consistent with recommendations by The Leap Frog Group, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ) and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic submissions. This incentive program is expected to evolve over time.

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

**Ambulatory Surgical Centers (ASCs)**

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

**Physician Group Practices and Physician Associations**

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

**Ancillary Service Providers**

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

**Mental Health/Substance Abuse**

A mental health/Substance Abuse (“behavioral health”) management company administers most of our behavioral health benefits, provides a network of Participating behavioral health providers and processes the related claims. The behavioral health management company is paid a set dollar amount per Member per month (capitation) for each Member and is responsible for paying its contracted providers on a fee-for-service basis. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters. A subsidiary of Independence Blue Cross has a less than one percent ownership interest in this behavioral health management company.
**Description of Covered Services**

Subject to the Exclusions, conditions and Limitations of this plan, you are entitled to benefits for the Covered Services described in this **DESCRIPTION OF COVERED SERVICES** section. You may be required to make a Copayment or there may be limits on services and other cost sharing requirements as specified in the **SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS**. Additional Benefits may be provided by your Group through the addition of a Rider. If applicable, this benefit information is also included with this Handbook.

Most Covered Services are provided or arranged by your Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services that you need, a Referral to a Non-Participating Provider will be arranged by your Primary Care Physician, with approval by the HMO. See “Access to Primary Care, Specialist and Hospital Care” for procedures for obtaining Preapproval for use of a Non-Participating Provider.

If you should have questions about any information in this Handbook or need assistance at any time, contact Member Services by calling the telephone number shown on your ID Card.

Some Covered Services must be Preapproved before you receive the services. The Primary Care Physician or Referred Specialist must seek the HMO’s approval and confirm that coverage is provided for certain services. Preapproval of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Preapproval helps determine whether a different treatment may be available that is equally effective yet less traumatic. Preapproval also helps determine the most appropriate setting for certain services. If a Primary Care Physician or Referred Specialist provides Covered Services or Referrals without obtaining such Preapproval, you will not be responsible for payment. More information on Preapproval is found in the **USING THE HMO SYSTEM** and the **SERVICES AND SUPPLIES REQUIRING PREAPPROVAL RIDER**.

**Primary and Preventive Care**

You are entitled to benefits for Primary and Preventive Care Covered Services. These Covered Services are provided or arranged by your Primary Care Physician, as noted. The Primary Care Physician will provide a Referral, when one is required, to a Participating Professional Provider when your condition requires a Specialist’s Services.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. The Referral is valid for ninety (90) days from date of issue so long as you are still enrolled in this plan. Self-Referrals are excluded, except for Emergency Care or if covered by a Rider. Additional Covered Services recommended by the Referred Specialist will require another written or electronic Referral from your Primary Care Physician.

“Preventive Care” services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when you have no symptoms of disease.

“Primary Care” services generally describe health care services performed to treat an illness or injury.

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

Medical Care visits for the exam, diagnosis and treatment of an illness or injury by your Primary Care Physician. This also includes physical exams and routine child care, including well-baby visits.

For the purpose of this benefit, “Office Visits” include Medical Care visits to your Primary Care Physician’s office, during and after regular office hours, Emergency visits and visits to a Member’s residence, if within the Service Area.

Pediatric and Adult Immunizations

Certain pediatric and adult Immunizations are Covered Services. Coverage for child Immunizations includes the immunizing agents, which as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits, but not applicable Copayments.

Routine Gynecological Exam, Pap Smear

Female Members are covered for one (1) routine gynecological exam each calendar year, This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have “direct access” to care by a participating obstetrician or gynecologist. This means there is no Primary Care Physician Referral needed.

Mammograms

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

Inpatient Covered Services

Services for Inpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by the your Primary Care Physician; and
- Preapproved by the HMO. Services that must be Preapproved are in the SERVICES AND SUPPLIES REQUIRING PREAPPROVAL RIDER.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. Your Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency Care or if covered by a Rider. Additional Covered Services recommended by the Referred Specialist will require another written or electronic Referral from your Primary Care Physician.
Hospital Services

A. 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 your 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. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
6. Therapy Services when administered by a person who is appropriately licensed and authorized to perform such services;
7. All Prescription 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. (The HMO reserves the right to apply quantity level limits as conveyed by the FDA or the HMO’s Pharmacy and Therapeutics Committee for certain Prescription Drugs);
8. Use of special care units, including, but not limited to, intensive or coronary care and related services;
9. Pre-admission testing.

B. Room and Board

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

1. An average semi-private room, as designated by the Hospital; or a private room, when designated by the HMO as semi-private for the purposes of this plan in Hospitals having primarily private rooms;
2. A private room, when Medically Necessary;
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.
Medical Care

Medical Care rendered by a Participating Professional Provider in charge of the case to you while an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to you while your condition requires a Referred Specialist’s constant attendance and treatment for a prolonged period of time.

A. Concurrent Care

Services rendered to you while an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Referred Specialist 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 you, standby services, routine preoperative physical exams or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by the Participating Facility Provider’s rules and regulations.

B. Consultations

Consultation services when rendered to you during an Inpatient Stay in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Referred Specialist at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by the Participating Facility Provider’s rules and regulations.

Skilled Nursing Care Facility

Benefits are provided for a Participating Skilled Nursing Care Facility, when Medically Necessary as determined by the HMO. You must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility.

During your admission, members of the HMO’s Care Management and Coordination team are monitoring your stay to assure that a plan for your discharge is in place. This is make sure that you have a smooth transition from the facility to home or other setting. A HMO Case Manager will work closely with your Primary Care Physician or the Referred Specialist to help with your discharge and if necessary, arrange for other medical services.

Should your Primary Care Physician or Referred Specialist agree with the HMO that continued stay in a Skilled Nursing Facility is no longer required, you will be notified in writing of this decision. Should you decide to remain in the facility after its notification the facility has the right to bill you after the date of the notification. Your may appeal this decision through the Grievance appeal process.
**Inpatient/Outpatient Covered Services**

Services for Inpatient / Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by the HMO. Services that must be Preapproved are in the SERVICES AND SUPPLIES REQUIRING PREAPPROVAL RIDER.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. Your Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency Care or if covered by a Rider. Additional Covered Services recommended by the Referred Specialist will require another written or electronic Referral from your Primary Care Physician.

**Autologous Blood Drawing/Blood/Storage/Transfusion**

Covered Services include the administration of blood and blood processing from donors. In addition, 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 are Covered Services.

Covered Services also include whole blood, blood plasma and blood derivatives, which are not classified as Prescription Drugs in the official formularies and which have not been replaced by a donor.

**Hospice Services**

Covered Services include palliative and supportive services provided to a terminally ill Member through a Hospice program by a Participating Hospice Provider. This also includes Respite Care. Two conditions apply for Hospice Benefit eligibility: (1) your Primary Care Physician or a Referred Specialist must certify for the HMO that you have a terminal illness with a medical prognosis of six (6) months or less; and (2) you must elect to receive care primarily to relieve pain. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help you cope with a terminal illness rather than cure it. Hospice Care provides services to make you as comfortable and pain-free as possible. When you elect to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, you may elect to revoke the election of Hospice Care at any time.

**Respite Care:** When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare-certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the your home.

Benefits for Covered Hospice Services are provided until the earlier date of your death or discharge from Hospice Care.
Maternity and Obstetrical Care Services

A. Maternity/Obstetrical Care

Services rendered in the care and management of your pregnancy are Covered Services under this plan. Your Referred Specialist will notify the HMO of your maternity care within one (1) month of the first prenatal visit to that Provider. Covered Services include: (1) facility services provided by a Participating Facility Provider that is a Hospital or Birth Center; and (2) professional services performed by a Referred Specialist that is a Physician or a certified nurse midwife. Benefits are also payable for certain services provided by Referred Specialists for elective home births.

Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries.

In the event of early post-partum discharge from an Inpatient Stay, benefits are provided for Home Health Care as described in the Home Health Care item under OUTPATIENT COVERED SERVICES.

B. Elective Abortions

Covered Services include services provided in a Participating Facility Provider that is a Hospital or Birth Center and services performed by a Referred Specialist for the voluntary termination of your pregnancy are Covered Services under this plan.

C. Newborn Care

Your newborn child shall be entitled to benefits provided by this plan from the date of birth up to a maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond thirty-one (31) days under conditions specified in the WHEN TO NOTIFY THE HMO OF A CHANGE section of this Handbook.

D. Artificial Insemination

Facility services provided by a Participating Facility Provider and services performed by a Referred Specialist for the promotion of fertilization of a female recipient’s own ova (eggs) by the introduction of mature sperm from partner or donor into the recipient’s vagina or uterus, with accompanying simple sperm preparation, sperm washing and/or thawing.

Mental Health Care and Serious Mental Illness Health Care

Benefits for the treatment of Mental Health Care and Serious Mental Illness Health Care are based on the services provided and reported by the Participating Behavioral Health/Substance Abuse Provider. When a Participating Professional Provider other than a Participating Behavioral Health/Substance Abuse Provider renders Medical Care to you, other than Mental Health Care or Serious Mental Illness Health Care, coverage for such Medical Care will be based on the Medical Benefits available, and will not be subject to the Mental Health Care and Serious Mental Illness Health Care Limitations shown in the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS.
A Referral from your Primary Care Physician is not required to obtain Inpatient or Outpatient Mental Health Care or Serious Mental Illness Health Care. You may contact your Primary Care Physician or call: 1-800-688-1911.

A. Inpatient Mental Health Care and Serious Mental Illness Health Care

Benefits are provided for Covered Services during an Inpatient Mental Health Care or Serious Mental Illness Health Care admission for

1. The treatment of a Mental Illness, including a Serious Mental Illness;
2. Provided by a Participating Behavioral Health/Substance Abuse Provider.

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

B. Outpatient Mental Health Care and Serious Mental Illness Health Care

Benefits are provided for Covered Services during an Outpatient Mental Health Care or Serious Mental Illness Health Care visit/session:

1. For the treatment of a Mental Illness, including a Serious Mental Illness; and
2. When provided by a Participating Behavioral Health/Substance Abuse Provider.

Outpatient Care Covered Services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, Participating Licensed Clinical Social Worker visits, Masters Prepared Therapist visits, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

Routine Costs Associated With Qualifying Clinical Trials

Benefits are provided for Routine Costs Associated With Participation in a Qualifying Clinical Trial (see the IMPORTANT DEFINITIONS section). To ensure coverage, the HMO must be notified in advance of the Member’s participation in a Qualifying Clinical Trial.

Substance Abuse Treatment

Benefits for the treatment of Substance Abuse are based on the services provided and reported by the Participating Behavioral Health/Substance Abuse Provider.

A Referral from Your Primary Care Physician is not required to obtain Inpatient or Outpatient Substance Abuse Treatment. You may contact your Primary Care Physician or call: 1-800-688-1911.

A. Inpatient Substance Abuse Treatment

Benefits are provided for Covered Services during an Inpatient Substance Abuse Treatment admission:

1. For the diagnosis and medical treatment of Substance Abuse, including Detoxification; and
2. At a Participating Facility Provider that is a Behavioral Health/Substance Abuse Provider.

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

Inpatient Benefits include:

1. Lodging and dietary services;
2. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
3. Services provided by a staff Physician, Psychologist, registered or Licensed Practical Nurse, and/or certified addictions counselor;
4. Rehabilitation therapy and counseling;
5. Family counseling and intervention; and
6. Prescription Drugs, medicines, supplies and use of equipment provided by the Substance Abuse Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Substance Abuse Provider.

B. Outpatient Substance Abuse Treatment

Benefits are provided for Covered Services during an Outpatient Substance Abuse Treatment visit/session:

1. For the diagnosis and medical treatment of Substance Abuse, including Detoxification; and
2. At a Participating Facility Provider that is a Behavioral Health/Substance Abuse Provider.

Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling during an Outpatient Substance Abuse Treatment visit/session in a Substance Abuse Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Substance Abuse Provider.

Outpatient Substance Abuse Treatment Covered Services include:

1. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
2. Services provided by the Behavioral Health/Substance Abuse Providers on staff;
3. Rehabilitation therapy and counseling;
4. Family counseling and intervention; and
5. Covered Prescription Drugs, medicines, supplies and use of equipment provided by the Substance Abuse Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Substance Abuse Provider.
Surgical Services

Covered Services for Surgery include services provided by a Participating Provider, professional or facility, for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Covered Services also include:

A. Congenital Cleft Palate

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

B. Mastectomy Care

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.

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

D. 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 you have an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure your health. Dental procedures or Surgery performed during such a confinement will only be covered for the services described in items 5 and 6 below.

E. Oral Surgery

Oral Surgery is subject to special conditions as described below:

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

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

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

   (c) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic Surgery will decrease airway resistance, improve breathing, or restore swallowing.
2. Other oral Surgery - defined as Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered Service will only be provided for:
   (a) Surgical removal of impacted teeth which are partially or completely covered by bone;
   (b) Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
   (c) Surgical removal of teeth prior to cardiac Surgery, Radiation Therapy or organ transplantation.

F. Assistant at Surgery

Benefits are provided for an assistant surgeon’s services if:
   1. The assistant surgeon actively assists the operating surgeon in the performance of covered Surgery;
   2. An intern, resident, or house staff member is not available; and
   3. Your condition or the type of Surgery must require the active assistance of an assistant surgeon as determined by the HMO.

G. Anesthesia

Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Referred Specialist other than the surgeon, assistant surgeon or attending Referred Specialist.

H. 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 Referred Specialist other than the one who initially recommended performing the Surgery.

Transplant Services

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

The determination of Medical Necessity for transplants will take into account the proposed procedure’s suitability for the potential recipient and the availability of an appropriate facility for performing the procedure.
Eligibility for Covered Services related to human organ, bone and tissue transplant are as follows.

If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

1. When both the recipient and the donor are Members, each is entitled to the benefits of this plan.

2. When only the recipient is a Member, both the donor and the recipient are entitled to the Benefits of this Member Handbook. However, donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.

3. When only the donor is a Member, the donor is entitled to the Benefits of this Member Handbook, subject to following additional limitations:
   
   (a) The Benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Member Handbook; and

   (b) No Benefits will be provided to the non-Member transplant recipient.

4. If any organ or tissue is sold rather than donated to the Member recipient, no Benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered. Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program.

Covered Services of a donor include:

a) Removal of the organ;

b) Preparatory pathologic and medical examinations; and

c) Post-surgical care.

**Outpatient Covered Services**

Services for Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by the HMO. Services that must be Preapproved are in the SERVICES AND SUPPLIES REQUIRING PREAPPROVAL RIDER.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. The Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency Care or if covered by a Rider. Additional Covered Services recommended by the Referred Specialist will require another written or electronic Referral from your Primary Care Physician.
**Ambulance Services**

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

A. the vehicle is licensed as an ambulance where required by applicable law;

B. the ambulance transport is appropriate for the patient’s clinical condition;

C. the use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would be contraindicated (i.e. would endanger the patient’s medical condition); and,

D. the ambulance transport satisfies the destination and other requirements stated below in either Section A. For Emergency Ambulance transport or Section B. For Non-Emergency Ambulance transport.

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

1. For Emergency Ambulance transport:
   - The Ambulance must be transporting the Member from the Member’s home or the scene of an accident or Medical Emergency to the nearest Hospital, or other facility that provides Emergency care, that can provide the Medically Necessary Covered Services for the Member’s condition.

2. For Non-Emergency Ambulance transport:
   - All non-emergency ambulance transports must be Preapproved by the HMO to determine Medical Necessity which includes specific origin and destination requirements specified in the HMO's policies.
   - Non-emergency ambulance transports are not provided for the convenience of the Member, the family, or the Provider treating the Member.

**Day Rehabilitation Program**

Covered Service will be provided for a Day Rehabilitation Program when provided by a Participating Facility Provider under the following conditions:

A. The Member requires intensive Therapy Services, such as Physical, Occupational and/or Speech Therapy five (5) days per week;

B. The Member has the ability to communicate verbally or non-verbally, the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;

C. The Member is willing to participate in a Day Rehabilitation Program; and

D. The Member’s family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.
**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 Participating Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that you require diabetic education on an Outpatient basis under the following circumstances:

A. Upon the initial diagnosis of diabetes;
B. A significant change in the patient’s symptoms or condition; or
C. 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 are Covered Services when provided by a Participating Facility Provider or a Participating Ancillary Provider. The Diabetic Education Program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the HMO. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

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

A. Initial assessment of the your needs;
B. Family involvement and/or social support;
C. Psychological adjustment for the patient;
D. General facts/overview on diabetes;
E. Nutrition including its impact on blood glucose levels;
F. Exercise and activity;
G. Medications;
H. Monitoring and use of the monitoring results;
I. Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
J. Use of community resources; and
K. Pregnancy and gestational diabetes, if applicable.

**Diabetic Equipment and Supplies**

Benefits shall be provided, subject to any applicable Copayment or cost sharing requirements applicable to Durable Medical Equipment benefits. If this plan provides benefits for Prescription Drugs (other than coverage for insulin and oral agents only), Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, subject to the cost-sharing arrangements applicable to the Prescription Drug coverage.
A. Diabetic Equipment
   1. Blood glucose monitors;
   2. Insulin pumps;
   3. Insulin infusion devices; and

B. Diabetic Supplies
   1. Blood testing strips;
   2. Visual reading and urine test strips;
   3. Insulin and insulin analogs*;
   4. Injection aids;
   5. Insulin syringes;
   6. Lancets and lancet devices;
   7. Monitor supplies;
   8. Pharmacological agents for controlling blood sugar levels;* and

* If your plan does not provide a Prescription Drug Rider, insulin and oral agents are covered as provided under the “Insulin and Oral Agents” benefits.

Diagnostic Services

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

A. Routine Diagnostic Services, including routine radiology (consisting of x-rays, ultrasound and nuclear medicine), routine medical procedures (consisting of Electrocardiogram (ECG), Electroencephalogram (EEG), Nuclear Cardiology Imaging, and other diagnostic medical procedures approved by the HMO) and allergy testing (consisting of percutaneous, intracutaneous and patch tests);

B. Non-Routine Diagnostic Services, including operative and diagnostic endoscopies, Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRI/MRA), Positron Emission Tomography (PET Scan), and Computed Tomography (CT Scan); and

C. Diagnostic laboratory and pathology tests.

D. Genetic testing including those testing services provided to a Member at risk by pedigree for a specific hereditary disease. The services must be for the purpose of diagnosis and where the results will be used to make a therapeutic decision.
**Durable Medical Equipment**

Benefits are provided for the rental (but not to exceed the total allowance of purchase) or, at the discretion of the HMO, the purchase of standard Durable Medical Equipment (DME) when:

A. It is used in the patient’s home; and

B. It is obtained through a Participating Durable Medical Equipment Provider.

Benefits are provided for the replacement of a previously approved DME item with an equivalent DME item when the following are true:

A. There is a change in your condition that requires a replacement; or

B. The DME breaks and exceeds its life duration as determined by the manufacturer.

Benefits will be provided for the repair of DME when the cost to repair is less than the cost to replace it. Repair means the restoration of the DME or one of its components to correct problems due to wear or damage. Replacement means the removal and substitution of DME or one of its components necessary for proper functioning.

If an item breaks and is under warranty, unless it is a rental item, it is your responsibility to work with the manufacturer to replace or repair it.

We will neither replace nor repair the DME due to abuse or loss of the item.

**Home Health Care**

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

A. Professional services of appropriately licensed and certified individuals;

B. Intermittent Skilled Nursing Care;

C. Physical Therapy;

D. Speech Therapy;

E. Well mother/well baby care following release from an Inpatient maternity stay; and

F. Care within forty-eight (48) hours following release from an Inpatient admission when the discharge occurs within forty-eight (48) hours following a mastectomy.

With respect to Item 5 above, Home Health Care services will be provided within forty-eight (48) hours if discharge occurs earlier than forty-eight (48) hours of a vaginal delivery or ninety-six (96) hours of a cesarean delivery. No Copayment 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 HMO.
Home Health Care benefits will be provided only when Prescribed by in a written Plan of Treatment and approved by the HMO.

There is no requirement that you 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 you immediately following an Inpatient release for maternity care, you must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

**Injectable Medications**

Benefits will be provided for Injectable Medications required in the therapeutic treatment of an injury or illness Prescribed by a Participating Professional Provider and required for therapeutic use, when determined to be Medically Necessary by the HMO.

A. Biotech/Specialty Injectables

Refers to injectable medications listed in the separate BIOTECH/SPECIALTY INJECTABLE DRUGS REQUIRING PREAPPROVAL RIDER. Preapproval is required for those Biotech/Specialty Injectables noted in the list. The purchase of all Biotech/Specialty Injectables is subject to a Copayment shown in the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS. Copayment amounts will apply: (a) to each thirty day supply of medication dispensed for medications administered on a regularly scheduled basis; or (b) to each course/series of injections if administered on an intermittent basis. A ninety (90) day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness; in such a case, the Member will be subject to three (3) Copayments, if applicable.

B. Standard Injectables

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

**Insulin and Oral Agents**

Benefits will be provided for Insulin and oral agents to control blood sugar when Prescribed by your Primary Care Physician or Referred Specialist. Generically equivalent pharmaceuticals will be dispensed whenever applicable.

**Medical Foods and Nutritional Formulas**

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an Outpatient basis either orally or through a tube.
Benefits are also payable for Nutritional Formulas when:

A. The Nutritional Formula is given by way of a tube into the alimentary tract; or

B. 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 Participating Durable Medical Supplier or in connection with Infusion Therapy as provided for in this plan.

**Non-Surgical Dental Services**

Covered Services are only provided for:

A. The initial treatment of Accidental Injury/trauma, (i.e. fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, consisting of the first caps, crowns, bridges and dentures (but not dental implants), required for the initial treatment for the Accidental Injury/trauma.

B. The preparation of the jaws and gums required for initial replacement of Sound Natural Teeth.

**Orthotics**

Benefits are provided for:

A. The initial purchase and fitting (per medical episode) of orthotic devices, except foot orthotics unless the Member requires foot orthotics as a result of diabetes.

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

**Private Duty Nursing Services**

Benefits will be provided for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by your Primary Care Physician, a Referred Specialist as a part of home health care treatment plan and which are Medically Necessary.

**Prosthetic Devices**

Benefits will be provided for Prosthetic Devices required as a result of illness or injury. Benefits include but are not limited to:

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

B. Supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
C. Visual Prosthetics when Medically Necessary and Prescribed for one of the following conditions:

1. Initial contact lenses Prescribed for the treatment of infantile glaucoma;
2. Initial pinhole glasses Prescribed for use after Surgery for detached retina;
3. Initial corneal or scleral lenses Prescribed in connection with the treatment of keratoconus or to reduce a corneal irregularity (other than astigmatism);
4. Initial scleral lenses Prescribed to retain moisture in cases where normal tearing is not present or adequate; and
5. An initial pair of basic eyeglasses when Prescribed to perform the function of a human lens lost (aphakia) as a result of:
   (i) Accidental Injury;
   (ii) trauma; or
   (iii) ocular Surgery

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

Benefits are provided for the replacement of a previously approved Prosthetic Device with an equivalent Prosthetic Device when:

A. There is a significant change in the Member’s condition that requires a replacement;
B. The Prosthetic Device breaks because it is defective;
C. The Prosthetic Device breaks because it has exceeded its life duration as determined by the manufacturer; or
D. The Prosthetic Device needs to be replaced for a Dependent child due to the normal growth process when Medically Necessary.

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

If an item breaks and is under warranty, it is your responsibility to work with the manufacturer to replace or repair it. We will neither replace nor repair the Prosthetic Device due to abuse or loss of the item.

**Specialist Office Visit**

Benefits will be provided for Specialist Services Medical Care provided in the office by a Referred Specialist. For the purpose of this benefit, “in the office” includes Medical Care visits to the Provider’s office, Medical Care visits by the Provider to your residence, or Medical Care consultations by the Provider on an Outpatient basis.
Spinal Manipulation Services

Benefits are 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.

Therapy Services

Benefits are provided for the following forms of therapy:

A. Cardiac Rehabilitation Therapy

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

B. Chemotherapy

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

C. Dialysis

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

D. Infusion Therapy

Treatment includes, but is not limited to, infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy. Services associated with home infusion are Covered Services when the home infusion is covered.

E. Occupational Therapy

Coverage will also include services rendered by a registered, licensed occupational therapist. You are required to have these services performed by your Primary Care Physician’s Designated Provider.

F. Orthoptic / Pleoptic Therapy

Benefits will be provided for treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye Surgery, or injury resulting in the lack of vision depth perception.
G. 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. You are required to have these services performed by your Primary Care Physician’s Designated Provider.

H. Pulmonary Rehabilitation Therapy

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

I. Radiation Therapy

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

J. 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.
**Exclusions—What Is Not Covered**

The following are excluded from your coverage:

1. Services, supplies or charges which are:
   
   A. Not provided by or Referred by the Member’s Primary Care Physician except in an Emergency; or as specified elsewhere in this Handbook; or
   
   B. Not Medically Necessary, as determined by the Primary Care Physician or Referred Specialist or the HMO, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under the Contract and described in this Handbook; or
   
   C. Provided by family members, relatives and friends;

2. Services for any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of Worker’s Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Member claims the benefits or compensation;

3. For any loss sustained or expensed Incurred during military service while on active duty as member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;

4. Any charges for services, supplies or treatment while a Member is incarcerated in any adult of juvenile penal or correctional facility of institution;

5. Care for conditions that federal, state or local law requires to be treated in a public facility;

6. Services, supplies or charges paid or payable by Medicare when Medicare is primary. For purposes of the Contract and Handbook, a service, supply or charge is “payable under Medicare” when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premiums for, maintains, claims or receives Medicare benefits.

7. For injuries resulting from the maintenance or use of a motor vehicle if the treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan;

8. Dental services and devices related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in the Contract or Handbook. Services not covered include, but are not limited to: apicoectomy (dental root resection); prophylaxis of any kind; root canal treatments; soft tissue impactions; alveolectomy; bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise described in the Contract and Handbook;
   
   A. For dental implants for any reason;
   
   B. For dentures, unless for the initial treatment of an Accidental Injury/trauma;
C. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;

D. For oral devices used for temporomandibular joint syndrome or dysfunction;

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

9. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a Prescribed Plan of Treatment;

10. Services or supplies which are Experimental or Investigational, except Routine Costs Associated With Qualifying Clinical Trials that have been Preapproved by the HMO;

Routine costs do not include any of the following:

A. The Experimental or Investigational drug, biological product, device, medical treatment or procedure itself.

B. The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

C. The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

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

12. Cosmetic Surgery, including cosmetic dental Surgery. Cosmetic Surgery is defined as any Surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected.

This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to the ears, lips, chin, jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

This exclusion does not include those services performed when the patient is a Member of the HMO and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process.

This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities for children;

13. Any therapy service provided for: ongoing outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond the plan’s day limits, if any, shown on the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;
14. For Maintenance of chronic conditions, injuries or illness;

15. Vision care including, but not limited to:
   A. All surgical procedures performed solely to eliminate the need for or reduce the Prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty;
   B. Any eyeglasses, lenses or contact lenses and the vision examination for Prescribing or fitting eyeglasses or contact lenses except as otherwise described in this Handbook; and
   C. Lenses which do not require a Prescription;
   D. Any lens customization such as, but not limited to tinting, oversize or progressive lenses; antireflective coatings, U-V lenses or coatings, scratch resistant coatings, mirror coatings, or polarization;
   E. Deluxe frames; or
   F. Eyeglass accessories such as cases, cleaning solution and equipment.

16. Any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Developmental Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;

17. Immunizations required for employment purposes or travel;

18. Custodial and Domiciliary Care, residential care, protective and supportive care, including educational services, rest cures and convalescent care;

19. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary. This exclusion does not apply to the HMO's weight reduction program;

20. For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements, including basic milk, soy, or casein hydrolyzed formulas (e.g. Nutramigen, Alimentum, Presgetimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy.

21. Customized wheelchairs;

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

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

24. Marriage or religious counseling;

25. In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT)) and any services required in connection with these procedures;
26. Reversal of voluntary sterilization and services required in connection with such procedures;

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

28. Ambulance service, unless Medically Necessary;

29. Services required by a Member donor related to organ donation. Expenses for donors donating organs to Member recipients are covered only as described in this Handbook. No payment will be made for human organs which are sold rather than donated;

30. Charges for completion of any insurance form;

31. Treatment for injuries sustained while committing a felony; or while intoxicated or under the influence of any narcotic not Prescribed or authorized by the Primary Care Physician;

32. For Prescription Drugs and medications, except as may be provided under a Prescription Drug rider attached to this Handbook; for over the counter drugs or any other medications that may be dispensed without a doctor’s prescription, except for medications administered during an Inpatient Stay;

33. Contraceptive devices;

34. Foot orthotic devices and the repair or replacement of external Prosthetic Devices, except as described in this Handbook.

   This exclusion does not apply to foot orthotic devices used for the treatment of diabetes;

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

36. Any services, supplies or treatments not specifically listed in this Handbook as covered Benefits, unless the unlisted Benefit, service or supply is a basic health service required by the Pennsylvania Department of Health. The HMO reserves the right to specify Providers of, or means of delivery of Covered Services, supplies or treatments under this plan, and to substitute such Providers or sources where medically appropriate;

37. The following outpatient services that are not performed by your Primary Care Physician’s Designated Provider, when required under the Plan, unless Preapproved by the HMO: (a) rehabilitation Therapy Services (other than Speech Therapy); (b) certain podiatry services if you are age nineteen (19) or older; and (c) diagnostic radiology services if you are age five (5) or older;

38. For Cognitive Rehabilitative Therapy;

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

41. Services, charges or supplies for which a Member would have no legal obligation to pay, or another party has primary responsibility;

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

43. Any charges for the administration of injectable insulin;

44. Services Incurred prior to the Member’s effective date;

45. Services which were or are Incurred after the date of termination of the Member’s coverage, except as provided in this Handbook;

46. Services received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trust or similar person;

47. Charges not billed/performed by a Provider;

48. Services performed by a Professional Provider enrolled in an educational or training program when such services are related to the educational or training program and are provided through a hospital or university;

49. Charges in excess of benefit maximums;

50. Counseling with patient’s relatives except as may be specifically provided in the subsection entitled “Substance Abuse Treatment” or “Transplant Services”;

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

52. Equipment costs related to services performed on high cost technological equipment as unless the acquisition of such equipment was approved through a Certificate of Need process and/or the HMO;

53. Equipment for which any of the following statements are true is not DME and will not be covered. Any item:

   A. That is for comfort or convenience. Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps, and telephone alert systems; bed-wetting alarms; and, ramps.

   B. That is inappropriate for home use. This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; transfillt chairs; and any devices used in the transmission of data for telemedicine purposes.

   C. That is a non-reusable supply or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not covered include, but are not limited to: incontinence pads; lambs wool pads; ace bandages; antiembolism stockings; catheters (non-urinary); face masks (surgical); disposable gloves, sheets and bags; and irrigating kits.
D. That is not primarily medical in nature. Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered “medical” equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to: ear plugs; exercise equipment; ice pack; speech teaching machines; strollers; silverware/utensils; feeding chairs; toileting systems; toilet seats; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.

E. That has features of a medical nature which are not required by the patient’s condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.

F. That duplicates or supplements existing equipment for use when traveling or for an additional residence. For example, a patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would not be eligible for two identical items, or one for each living space.

G. Which is not customarily billed for by the Provider. Items not covered include, but are not limited to: delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.

H. That modifies vehicles, dwellings, and other structures. This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person’s disability or (ii) any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair. The HMO will neither replace nor repair the DME due to abuse or loss of the item.

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

55. For Skilled Nursing Facility benefits:
   A. When confinement is intended solely to assist a Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
   B. For the treatment of Substance Abuse and Mental Illness Health Care; or
   C. After the Member 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;

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

57. Services for repairs or replacements of Prosthetic Devices needed because the prosthesis was abused or misplaced;
58. For Alternative Therapies/Complementary Medicine, including but not limited to: acupuncture; music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; rolfing; psychodrama; vitamin or other dietary supplements and therapy; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; and sleep therapy;

59. Any Mental Health Care, Serious Mental Illness Health Care, or Substance Abuse Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as: Alternative Therapies/Complementary Medicine and obesity control therapy;

60. For Home Health Care services and supplies in connection with home health services for the following:
   A. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
   B. Rental or purchase of Durable Medical Equipment;
   C. 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 conditioner and similar services, appliances an devices;
   D. Prescription drugs;
   E. Provided by family members, relatives, and friends;
   F. A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
   G. Emergency or non-emergency Ambulance services;
   H. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
   I. Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
   J. Visits by any Provider personnel solely for the purpose of assessing a Member’s condition and determining whether or not the Member requires and qualifies for Home Health Care services by the Provider.

61. Treatment of obesity, except for surgical treatment of obesity when the HMO;
   A. Determines the Surgery is Medically Necessary; and
   B. The Surgery is not a revision, repeat or reversal of any previous obesity Surgery. The exclusion of coverage for a revision, repeat or reversal of any previous obesity Surgery does not apply when required for complications which, if left untreated, would result in endangering the health of the Member;

62. For services, supplies or charges a Member is legally entitled to receive when provided by the Veteran’s Administration or by the Department of Defense in a government facility reasonably accessible by the Member;

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

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

For the purposes of this Member Handbook, the terms below have the following meaning:

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

• ACCREDITED EDUCATIONAL INSTITUTION—a publicly or privately operated academic institution of higher learning which: (a) provides a 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 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.

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

• AMBULATORY SURGICAL FACILITY—a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the HMO 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 SERVICE PROVIDER**—an individual or entity that provides services, supplies or equipment (such as, but not limited to, Home Infusion Therapy Services, Durable Medical Equipment and ambulance services), for which benefits are provided under the coverage.

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

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

- **AWAY FROM HOME CARE COORDINATOR**—the staff whose functions include assisting Members with registering as a Guest Member for Guest Membership Benefits under the Away From Home Care Program.

- **AWAY FROM HOME CARE PROGRAM**—a program, made available to independent licensees of the Blue Cross Blue Shield Association, that provides Guest Membership Benefits to Members registered for the Program while traveling out of the HMO’s Service Area for an extended period of time. TheAway From Home Care Program offers portable HMO coverage to Members traveling in a Host HMO Service Area. Registration for Guest Membership Benefits under the Away From Home Care Program is coordinated by the Away From Home Care Coordinator.

- **BENEFITS**—see Covered Service.

- **BIRTH CENTER**—a Facility Provider approved by the HMO 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.

- **BLUECARD PROGRAM**—a program that enables Members obtaining health care services while traveling outside the HMO’s Service Area to receive all the same benefits of their Plan and access to BlueCard Traditional Providers and savings. The program links participating health care providers and the independent Blue Cross and Blue Shield Licensees across the country and also to some international locations through a single electronic network for claims processing and reimbursement.

- **CARDIAC REHABILITATION THERAPY**—a medically supervised rehabilitation program designed to improve a patient’s tolerance for physical activity or exercise.

- **CASE MANAGEMENT**—Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Member to ensure the efficient use of appropriate health care resources, link Members with appropriate health care or support services, assist PCP’s and Referred Specialists in coordinating Prescribed services, monitor the quality of services delivered, and improve Member outcomes. Case Management supports Members, PCP’s and Referred Specialists by locating, coordinating, and/or evaluating services for a Member who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.
• **CERTIFIED REGISTERED NURSE**—a Certified Registered Nurse anesthetist, Certified Registered Nurse practitioner, certified entero stomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

• **CHEMOTHERAPY**—the treatment of malignant disease by chemical or biological antineoplastic agents.

• **COGNITIVE REHABILITATIVE THERAPY**—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.

• **COINSURANCE**—the percentage of the HMO fee schedule amount which must be paid by the Member (such as 20 percent).

• **COMPLAINT**—a dispute or objection regarding coverage, including exclusions and non-Covered Services under the plan, Participating or Non-Participating Providers’ status or the operations or management policies of the HMO. This definition does not include a Grievance appeal (Medical Necessity appeal). It also does not include disputes or objections that were resolved by the HMO and did not result in the filing of a Complaint appeal (written or oral).

• **CONTRACT (GROUP MASTER CONTRACT)**—the agreement between the HMO and the Group, including the Enrollment/Change Forms, Cover Sheet, Group Application, Acceptance Sheet, schedules, Handbook, Riders and/or amendments if any, also referred to as the Group Contract.

• **CONTROLLED SUBSTANCE**—any medicinal substance as defined by the Drug Enforcement Administration which requires a Prescription Order in accordance with the Controlled Substance Act – Public Law 91-513.

• **COORDINATION OF BENEFITS (COB)**—a provision that is intended to avoid claims payment delays and duplication of Benefits when a person is covered by two or more group plans providing Benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims, and by providing the authority for the orderly transfer of information needed to pay claims promptly. It avoids duplication of Benefits by permitting a reduction of the Benefits of a plan when, by the rules established by this provision, that plan does not have to pay Benefits first. This provision does not apply to student accident or group hospital indemnity plans paying one hundred dollars ($100) per day or less.

• **COPAYMENT**—a specified dollar amount or a percentage of a contracted fee amount that is applied to a specific Covered Service for which the Member is responsible per Covered Service. Copayments, if any, are identified in the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS.

• **COVERED SERVICE**—a service or supply specified in the DESCRIPTION OF COVERED SERVICES section of this Member Handbook, for which benefits will be provided.
• **CUSTODIAL CARE (DOMICILIARY CARE)**—care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision of self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

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

• **DECISION SUPPORT**—Decision Support describes a variety of services that help Members make educated decisions about health care and support their ability to follow their PCP’s and Referred Specialist treatment plans. Some examples of Decision Support services include support for major treatment decisions and information about everyday health concerns.

• **DEPENDENT**—an individual who resides in the Service Area, for whom Medicare is not primary pursuant to any federal or state regulation, law or ruling, who meets all the eligibility requirements established by the Group and the HMO, who is enrolled under the HMO coverage, and who is:

A. The Subscriber’s legal spouse (common-law marriages must be documented to the satisfaction of the HMO); or

B. The Subscriber’s or the Subscriber’s legal spouse’s unmarried child (natural, legally adopted or placed for adoption, or stepchild), or child for whom the Subscriber or the Subscriber’s legal spouse is a court appointed legal guardian. Such child must be within the Limiting Age for Dependents.

C. An unmarried child, regardless of age, who, in the judgment of the HMO, is incapable of self-support due to a mental or physical handicap which commenced prior to the child’s reaching the Limiting Age for Dependents and for which continuing justification may be required by the HMO.

D. An unmarried child within the Limiting Age for Dependents who resides in the Service Area and is a full-time student in an Accredited Educational Institution for which continuing justification is required; or

E. A Dependent of a Subscriber who is enrolled in the HMO’s Medicare risk program. A Dependent child of such Subscriber must be within the Limiting Age for Dependents; or

F. An unmarried child who is past the Limiting Age for Dependents and who: (1) is a full-time student; (2) is eligible for coverage under this Member Handbook; and (3) prior to attaining the Limiting Age for Dependents and while a full-time student was (a) a member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and who was called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or (b) a member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.
Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent’s service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

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

G. The newborn child of a Member for the first thirty-one (31) days immediately following birth. Coverage will continue in effect thereafter if the newborn qualifies as a Dependent, is enrolled by the Subscriber within thirty-one (31) days of birth, and any appropriate payment due, calculated from the date of birth, is received by the HMO (also see “New Child” under “When to Notify The HMO of a Change”). Under the Plan no other Benefits, except conversion privileges, will be extended to the newborn child of a Dependent unless such newborn child meets the eligibility requirements of a Dependent set forth in this section and is enrolled as a Dependent within thirty-one days of eligibility.

- **DESIGNATED PROVIDER**—a Participating Provider with whom the HMO has contracted the following outpatient services: (a) certain rehabilitation Therapy Services (other than Speech Therapy); (b) podiatry services for Members age nineteen (19) or older; or (c) diagnostic radiology services for Members age five (5) or older. The Member’s Primary Care Physician will provide a Referral to the Designated Provider for these services.

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

- **DIABETIC EDUCATION PROGRAM**—an outpatient diabetic education program provided by a Participating Facility Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

- **DIALYSIS**—treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

- **DISEASE MANAGEMENT**—a population-based approach to identify Members who have or are at risk for a particular chronic medical condition, intervene with specific programs of care, and measure and improve outcomes. Disease Management programs use evidence-based guidelines to educate and support Members, PCP’s and Referred Specialists, matching interventions to Members with greatest opportunity for improved clinical or functional outcomes. Disease Management programs may employ education, PCP’s and Referred Specialists feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist Members with chronic disease(s). Disease Management interventions are intended to both improve delivery of services in various active stages of the disease process as well as to reduce/prevent relapse or acute exacerbation of the condition.
• **DRUG FORMULARY**—a listing of Prescription Drugs preferred for use by the HMO. This list shall be subject to periodic review and modification by the HMO.

• **DURABLE MEDICAL EQUIPMENT (DME)**—equipment that meets all of these tests:
  
  A. It is Durable. (This is an item that can withstand repeated use.)
  
  B. It is Medical Equipment. (This is equipment that is primarily and customarily used for medical purposes, and is not generally useful in the absence of illness or injury.)
  
  C. It is generally not useful to a person without an illness or injury.
  
  D. It is appropriate for use in the home.

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

• **EFFECTIVE DATE OF COVERAGE**—the date coverage begins for a Member. All coverage begins at 12:01 a.m. on the date reflected on the records of the HMO.

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

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

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

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

• **ENROLLMENT/CHANGE FORM**—the properly completed, written request for enrollment for HMO membership submitted in a format provided by the HMO, together with any amendments or modifications thereof.

• **ENTERAL NUTRITION**—the provision of nutritional requirements into the alimentary tract.

• **EXPERIMENTAL/INVESTIGATIONAL SERVICES**—a drug, biological product, device, medical treatment or procedure which meets any of the following criteria is an Experimental/Investigational Service.

  A. It is the subject of ongoing Phase I or Phase II Clinical Trials.
  
  B. It is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
A drug will not be considered Experimental/Investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia recognize the usage as appropriate medical treatment. The compendia are:

- The American Hospital Formulary Service Drug Information or
- The United States Pharmacopeia Drug Information

In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been Prescribed will be considered Experimental/Investigational Services.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigational Services if it meets all of the criteria listed below in paragraphs A – E:

A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.
• **FACILITY PROVIDER**—an institution or entity licensed, where required, to provide care. Such facilities include:

  A. Ambulatory Surgical Facility  
  B. Birth Center  
  C. Free Standing Dialysis Facility  
  D. Free Standing Ambulatory Care Facility  
  E. Home Health Care Agency  
  F. Hospice  
  G. Hospital  
  H. Non-Hospital Facility  
  I. Psychiatric Hospital  
  J. Rehabilitation Hospital  
  K. Residential Treatment Facility  
  L. Short Procedure Unit  
  M. Skilled Nursing Facility

• **FOLLOW-UP CARE**—care scheduled for Medically Necessary follow-up visits that occur while the Member is away from home. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is still at home. An example is Dialysis. Follow-Up Care must be Preapproved by the Member’s Primary Care Physician prior to traveling. This service is available through the BlueCard Program for temporary absences (less than ninety (90) consecutive days) from the HMO’s Service Area.

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

• **FREE STANDING DIALYSIS FACILITY**—a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the HMO, which is primarily engaged in providing Dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.

• **GENERIC DRUG**—pharmacological agents approved by the FDA as a bioequivalent substitute and manufactured by a number of different companies as a result of the expiration of the original patent.

• **GRIEVANCE**—a request by a Member or a health care Provider, with the written consent of the Member, to have the HMO reconsider a decision solely concerning the Medical Necessity or appropriateness of a health care service. This definition does not include a Complaint appeal. It also does not include disputes or objections regarding Medical Necessity that were resolved by the HMO and did not result in the filing of a Grievance appeal (written or oral).

• **GROUP (CONTRACT HOLDER)**—the entity which established, sponsors, and/or maintains a welfare benefit plan for the purpose of providing health insurance benefits to plan participants or their beneficiaries, and which, on behalf of the welfare benefit plan, has agreed to remit payments to the HMO and to receive, on behalf of the enrolled Members, any information from the HMO related to the benefits provided to enrolled Members pursuant to the terms of the Contract.

• **GROUP CONTRACT**—see Contract.
• **GUEST MEMBER**—a Member who has a pre-authorized Guest Member registration in a Host HMO Service Area for a defined period of time. After that period of time has expired, the Member must again meet the eligibility requirements for Guest Membership Benefits under the Away From Home Care Program and re-enroll as a Guest Member to be covered for those Benefits.

A Subscriber’s eligible Dependent may register as a “Student Guest Member.” The Dependent must be a student residing outside the HMO’s Service Area and inside a Host HMO Service Area. The Dependent student must not be residing with the Subscriber and must be residing in a Host HMO Service Area.

• **GUEST MEMBERSHIP (GUEST MEMBERSHIP PROGRAM)**—a program that provides Guest Membership Benefits to Members while traveling out of the HMO’s Service Area for a period of at least ninety (90) consecutive days. Guest Membership Benefits provide coverage for a wide range of health care services. The Guest Membership Program offers portable HMO coverage to Members of plans contracting in the HMO’s network. Services provided under the Guest Membership Program are coordinated by the Guest Membership Coordinator. Guest Membership is available for a limited period of time. The Guest Membership Coordinator will confirm the period for which you are registered as a Guest Member.

• **GUEST MEMBERSHIP BENEFITS**—benefits available to Members while traveling out of the HMO’s Service Area for a period of at least ninety (90) consecutive days. Guest Membership Benefits provide coverage for a wide range of health care services. Members can register for Guest Membership Benefits available under the Away From Home Care Program by contacting the Away From Home Care Coordinator. The Away From Home Care Coordinator will also confirm the period for which the Member is registered as a Guest Member since Guest Membership Benefits are available for a limited period of time.

• **GUEST MEMBERSHIP COORDINATOR**—the staff that assists Members with registration for Guest Membership and provides other assistance to Members while Guest Members.

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

• **HOME**—for purposes of the Home Health Care and Homebound Covered Services only, this is the place where the Member lives. This may be a private residence/domicile, an assisted living facility, a long-term care facility or a Skilled Nursing Facility at a custodial level of care.

• **HOME HEALTH CARE PROVIDER**—a licensed Provider that has entered into an agreement with the HMO to provide home health care Covered Services to Members on an intermittent basis in the Member's Home in accordance with an approved home health care Plan of Treatment.
• **HOMEBOUND**—when there exists a normal inability to leave Home due to severe restrictions on the Member’s mobility and when leaving the Home:(a) would involve a considerable and taxing effort by the Member; and (b) the Member is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

• **HOSPICE**—a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

• **HOSPICE PROVIDER**—a licensed Provider that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people whose estimated survival is six (6) months or less. Covered Services to be provided by the Hospice Provider include Home Hospice and/or Inpatient Hospice services that have been referred by your Primary Care Physician and Preapproved by the HMO.

• **HOSPITAL**—a short term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the HMO 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 Substance Abuse; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

• **HOSPITAL SERVICES**—except as limited or excluded herein, acute-care Covered Services furnished by a Hospital which are Referred by your Primary Care Physician or provided by your Referred Specialist and Preapproved by the HMO where required, and set forth in the DESCRIPTION OF COVERED SERVICES.

• **HOST HMO**—the contracting HMO through which a Member can receive Away From Home Care Covered Services as a Guest Member when traveling in the Host HMO Service Area.

• **HOST HMO SERVICE AREA**—a Host HMO’s approved geographical area within which the Host HMO is approved to provide access to Covered Services.

• **IDENTIFICATION CARD (ID CARD)**—the currently effective card issued to the Member by the HMO which must be presented when a Covered Service is requested.
• **IMMEDIATE FAMILY**—the Employee’s spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

• **IMMUNIZATIONS**—Pediatric and Medically Necessary adult Immunizations (except those required for employment, or travel). Coverage will be provided for those child Immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits, but not applicable Copayments.

• **INCURRED**—a charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

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

• **INPATIENT CARE**—treatment received as a bed patient in a Hospital, a Rehabilitation Hospital, a Skilled Nursing Facility or a Participating Facility Provider that is a Behavioral Health/Substance Abuse Provider.

• **INPATIENT STAY (or INPATIENT)**—the actual entry into a Hospital, extended care facility or Facility Provider of a Member 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 Member is actually discharged from the facility.

• **KEYSTONE HEALTH PLAN EAST, INC. (“Keystone” or “the HMO”)**—a health maintenance organization providing access to comprehensive health care to Members.

• **LEGEND DRUG**—any medicinal substance which is required by the Federal Food, Drug and Cosmetic Act to be labeled as “Caution: Federal law prohibits dispensing without a prescription”.

• **LICENSED CLINICAL SOCIAL WORKER**—a social worker who has graduated from an Accredited Educational Institution with a Master’s or Doctoral degree and is licensed by the appropriate state authority.

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

• **LIMITATIONS**—the maximum number of Covered Services, measured in number of visits or days, or the maximum dollar amount of Covered Services that are eligible for coverage. Limitations may vary depending on the type of program and Covered Services provided. Limitations, if any, are identified in the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS.

• **LIMITING AGE FOR DEPENDENTS**—the age as shown in the SCHEDULE OF COINSURANCE, COPAYMENTS & LIMITATIONS, at which a Dependent child is no longer eligible as a Dependent under the Subscriber’s coverage. A Dependent child shall be removed from the Subscriber’s coverage at the end of the month in which the Limiting Age For Dependents is attained unless otherwise agreed to by the HMO and the Group.
• **MAINTENANCE**—continuation of care and management of the Member when:

A. The maximum therapeutic value of a Medically Necessary treatment plan has been achieved;

B. No additional functional improvement is apparent or expected to occur;

C. The provision of Covered Services ceases to be of therapeutic value; and

D. It is no longer Medically Appropriate/Medically Necessary.

This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

• **MASTERS PREPARED THERAPIST**—a therapist who holds a Master's Degree in an acceptable human services-related field of study and is licensed as a therapist at an independent practice level by the appropriate state authority to provide therapeutic services for the treatment of mental health care and Serious Mental Illness.

• **MEDICAL CARE**—services rendered by a Professional Provider within the scope of his license for the treatment of an illness or injury.

• **MEDICAL DIRECTOR**—a Physician designated by the HMO to design and implement quality assurance programs and continuing education requirements, and to monitor utilization of health services by Members.

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

• **MEDICAL SCREENING EVALUATION**—an examination and evaluation within the capability of the Hospital’s emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel.

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

• **MEDICALLY NECESSARY (MEDICAL NECESSITY)**—an intervention is Medically Necessary if it is recommended by the Primary Care Physician or Referred Specialist, and the HMO's Medical Director or Physician designee determines that it is all of the following:

A. It is a “health intervention”. A health intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a “medical condition” or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.
A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

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

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

1. New interventions – Effectiveness is determined by “scientific evidence”. An intervention is considered new if it is not yet in widespread use for: (a) the medical condition, and; (b) the patient indications being considered.

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

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

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

   And;

2. Existing interventions – Effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

   For existing interventions scientific evidence is considered first and, to the greatest extent possible, is the basis for determinations of Medical Necessity.

   If no scientific evidence is available, professional standards of care are considered.

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

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

   Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if: (a) there is strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care; or, (b) in the absence of such standards, convincing expert opinion.
D. It is cost-effective for this condition compared to alternative interventions, including no intervention. “Cost effective” does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual Member, the characteristics of the individual Member shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this definition of Medical Necessity. An intervention is covered if: (a) it is a Covered Service; (b) it is not excluded from your Coverage, and; (c) it is Medically Necessary.

- **MEDICARE**—the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- **MEMBER**—a Subscriber or Dependent who meets the eligibility requirements for enrollment. A Member does not mean any person who is eligible for Medicare except as specifically stated in this Handbook.
- **MENTAL ILLNESS**—any of various conditions categorized as mental disorders by the most recent edition of the International Classification of Diseases (ICD), wherein mental treatment is provided by a qualified Behavioral Health Provider. For purposes of this Contract and Handbook, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness because the benefit limits for Mental Illness and Serious Mental Illness are separate and not cumulative.
- **NON-HOSPITAL FACILITY**—a Facility Provider, licensed by the Department of Health for the care or treatment of Alcohol or Drug dependent persons, except for transitional living facilities. Non Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities and Freestanding Ambulatory Care Facilities.
- **NON-PARTICIPATING PROVIDER**—a Facility Provider, Professional Provider, Ancillary Service Provider that is not a member of the HMO’s Network.
- **NUTRITIONAL FORMULA**—liquid nutritional products which are formulated to supplement or replace normal food products.
- **OCCUPATIONAL THERAPY**—medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the Member’s ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.
- **OFFICE VISITS**—Covered Services provided in the physician’s office and performed by or under the direction of the Primary Care Physician or a Referred Specialist.
- **OUTPATIENT CARE**—medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a Hospital or other Inpatient facility.
• **OUTPATIENT MENTAL HEALTH CARE/OUTPATIENT SERIOUS MENTAL ILLNESS HEALTH CARE/OUTPATIENT SUBSTANCE ABUSE TREATMENT (OUTPATIENT TREATMENT)**—the provision of medical, nursing, counseling or therapeutic Covered Services on a planned and regularly scheduled basis at a Participating Facility Provider licensed by the Department of Health as a Substance Abuse treatment program or any other mental health or Serious Mental Illness therapeutic modality designed for a patient or client who does not require care as an Inpatient. Outpatient Treatment includes care provided under a partial hospitalization program or an intensive outpatient program.

Each outpatient visit or session is subject to the applicable Outpatient Mental Health Care Visits/Sessions Copayment, Outpatient Serious Mental Illness Health Care Visits/Sessions Copayment or Outpatient Substance Abuse Treatment Visits/Sessions Copayment.

• **PARTICIPATING FACILITY PROVIDER**—a Facility Provider that is a member of the HMO’s network.

• **PARTICIPATING PROFESSIONAL PROVIDER**—a Professional Provider who is a member of the HMO’s network.

• **PARTICIPATING PROVIDER**—a Facility Provider, Professional Provider or Ancillary Services Provider with whom the HMO has contracted directly or indirectly and, where applicable, is Medicare certified to render Covered Services. This includes, but is not limited to:

  A. **Primary Care Physician (PCP)** — a Participating Provider selected by a Member who is responsible for providing all primary care Covered Services and for authorizing and coordinating all covered Medical Care, including Referrals for Specialist Services.

  B. **Referred Specialist** — a Provider who provides Covered Specialist Services within his/her specialty and upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services, Referral to a Non-Participating Provider will be arranged by your Primary Care Physician with Preapproval by the HMO. See “Access to Primary, Specialist and Hospital Care” for procedures for obtaining Preapproval for use of a Non-Participating Provider.

  A Referred Specialist also includes Participating Professional Providers that provide the following designated services without a Referral: (1) routine maternity care, routine gynecological care, abortions, or specialty gynecological care in the Provider’s office other than reproductive endocrinology/infertility care and gynecological oncology care; and (2) Dialysis.

  For the following outpatient services, the Referred Specialist is your Primary Care Physician’s Designated Provider: (a) certain rehabilitation Therapy Services (other than Speech Therapy); (b) podiatry services, if you are age nineteen (19) or older; and (c) certain diagnostic radiology services, if you are age five (5) or older. Your Primary Care Physician will provide a Referral to the Designated Provider for these services.

  C. **Obstetricians and Gynecologists** — a Participating Provider selected by a female Member who provides the following designated services without a Referral: routine maternity care, routine gynecological care, abortions or specialty gynecological care in the Provider’s office. A Referral from a Primary Care Physician is required for all reproductive endocrinology/infertility care and gynecological oncology care services. All non-facility obstetrical and gynecological Covered Services are subject to the same Copayment that applies to Office Visits to your PCP.
D. **Participating Hospital** – a Hospital that has contracted with the HMO to provide Covered Services to Members.

E. **Durable Medical Equipment (DME) Provider** – a Participating Provider of Durable Medical Equipment that has contracted with the HMO to provide Covered Supplies to Members.

F. **Behavioral Health/Substance Abuse Provider** – a Provider in a network made up of professionals and facilities contracted by a behavioral health management company on the HMO’s behalf to provide behavioral health/Substance Abuse Covered Services for the treatment of Mental Illness, Serious Mental Illness and Substance Abuse, (including Detoxification) to the HMO’s Members. Licensed Clinical Social Workers and Masters Prepared Therapists are contracted to provide Covered Services for treatment of mental health care and Serious Mental Illness only.

G. **Hospice Provider** – a licensed Participating Provider that is primarily engaged in providing pain relief, symptom management, and supportive services to a terminally ill Member with a medical prognosis of six (6) months or less.

- **Pervasive Developmental Disorders (PDD)** – disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities. Examples are Asperger’s syndrome and childhood disintegrative disorder.

- **Pharmacist** – an individual, duly licensed as a Pharmacist by the State Board of Pharmacy or other governing body having jurisdiction, who is employed by or associated with a pharmacy.

- **Pharmacy and Therapeutics Committee** – a group composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee consists of at least two-thirds licensed and actively practicing physicians and Pharmacists and shall consist of at least one Pharmacist.

- **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.

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

- **Plan of Treatment** – a plan of care which is developed or approved by the Primary Care Physician 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 Necessary for the Member’s diagnosis and condition.
• **PREAPPROVED (PREAPPROVAL)**—the approval which the Primary Care Physician or Referred Specialist must obtain from the HMO to confirm the HMO coverage for certain Covered Services. Such approval must be obtained prior to providing Members with Covered Services or Referrals. Approval will be given by the appropriate HMO staff, under the supervision of the Medical Director. If the Primary Care Physician or Referred Specialist is required to obtain a Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment. Preapproval is not required for a maternity Inpatient Stay.

• **PRESCRIBE (PRESCRIBED)**—to write or give a Prescription Order.

• **PRESCRIPTION DRUG**—A Legend Drug or Controlled Substance, which has been approved by the Food and Drug Administration for a specific use and which can, under federal or state law, be dispensed only pursuant to a Prescription Order. You may call Member Services at the telephone number shown on your ID Card to find out if your Prescription Drug has been approved by the HMO or you may ask your Primary Care Physician to call Provider Services.

• **PRESCRIPTION ORDER**—the authorization for: 1) a Prescription Drug, or 2) services or supplies prescribed for the diagnosis or treatment of an illness, which are issued by a Primary Care Physician or Participating Provider who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

• **PRIVATE DUTY NURSING**—Medically Necessary continuous skilled nursing services provided to a Member by a by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

• **PROFESSIONAL PROVIDER**—a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are:
  - Audiologist
  - Certified Registered Nurse
  - Certified Nurse Midwife
  - Dentist
  - Independent Clinical Laboratory
  - Licensed Clinical Social Worker (for Mental Health Care and Serious Mental Illness services only)
  - Optometrist
  - Physical Therapist
  - Physician
  - Podiatrist
  - Psychologist
  - Speech-language Pathologist
  - Teacher of the hearing impaired

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

• **PROVIDER**—any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, certified nurse midwife, Hospital, Skilled Nursing Facility, Rehabilitation Hospital, birthing facility, or Home Health Care Provider. In addition, for Mental Health Care and Serious Mental Illness services only, a Licensed Clinical Social Worker and a Masters Prepared Therapist will also be considered a Provider.
• **PSYCHIATRIC HOSPITAL**—a Facility Provider, approved by the HMO, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

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

• **PULMONARY REHABILITATION**—multi-disciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

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

  A. It investigates a service that falls within a benefit category of this Contract.

  B. It is not specifically excluded from coverage.

  C. It has a therapeutic intent upon enrolled patients with diagnosed disease.

  D. It is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence.

  E. It does not duplicate existing studies.

  F. It is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial.

  G. It is designed and conducted according to appropriate standards of scientific integrity.

  H. It complies with Federal regulations relating to the protection of human subjects.

  I. It has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease.

  J. One of the following applies:

     (1) It is funded by, or supported by centers or cooperative groups that are funded by one of the following:

     • the National Institutes of Health (NIH)

     • Centers for Disease Control and Prevention (CDC)

     • Agency for Healthcare Research and Quality (AHRQ)

     • Centers for Medicare and Medicaid Services (CMS)

     • a research arm of the Department of Defense (DOD) or

     • Department of Veterans Affairs (VA).
(2) It is conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA.

K It is conducted by a Primary Care Physician, Referred Specialist or a non-participating specialist, when Preapproved by the HMO and conducted in a Participating Provider facility. If there is no comparable Clinical Trial (as defined above) being performed by, and in, Participating Providers, then the HMO will consider the services by Non-Participating Providers as covered. See “Access to Primary, Specialist and Hospital Care” for procedures for obtaining Preapproval for use of a Non-Participating Provider.

In the absence of meeting the criteria listed in A. – J. above, the Clinical Trial must be approved by the HMO as a Qualifying Clinical Trial.

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

• REFERRED (REFERRAL)—written or electronic documentation from the Member’s Primary Care Physician that authorizes Covered Services to be rendered by a Participating Provider or group of Providers or the Provider specifically named on the Referral. Referred care includes all services provided by a Referred Specialist. Referrals to Non-Participating Providers must be Preapproved by the HMO. A Referral must be issued to the Member prior to receiving Covered Services and is valid for ninety (90) days from the date of issue for an enrolled Member. See “Access to Primary Care Physician, Specialist and Hospital Care” for procedures for obtaining Preapproval for use of a Non-Participating Provider.

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

• RELIABLE EVIDENCE—Any of the following:

  A. Reports and articles that have been published in the authoritative medical and scientific literature.
  B. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure.
  C. The written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.
• **RESIDENTIAL TREATMENT FACILITY**—a Facility Provider, licensed and approved by the appropriate government agency and approved by the HMO, which provides treatment for Mental Illness, Serious Mental Illness or for Substance Abuse (alcohol and drug) and dependency to partial, outpatient or live in patients who do not require acute Medical Care.

• **RESPITE CARE**—Hospice services necessary to relieve primary caregivers, provided on a short term basis, in a Medicare certified Skilled Nursing Facility, to a Member for whom Hospice care is provided primarily in the home.

• **RIDER**—a legal document which modifies the protection of the Contract and this Handbook, either by expanding, decreasing or defining Benefits, or adding or excluding certain conditions from coverage under the Contract and this Handbook.

• **ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS**—Routine costs include all of the following:
  A. Covered Services under this Contract that would typically be provided absent a Qualifying Clinical Trial;
  B. Services and supplies required solely for the provision of the Experimental/Investigational drug, biological product, device, medical treatment or procedure;
  C. The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications;
  D. The services and supplies required for the diagnosis or treatment of complications.

• **SERIOUS MENTAL ILLNESS**—means any of the following biologically based mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistic Manual:
  A. Schizophrenia
  B. Bipolar disorder
  C. Obsessive-compulsive disorder
  D. Major depressive disorder
  E. Panic disorder
  F. Anorexia nervosa
  G. Bulimia nervosa
  H. Schizo-affective disorder
  I. Delusional disorder, and
  J. Any other Mental Illness that is considered to be “Serious Mental Illness” by law.
• **SERVICE AREA**—the geographical area within which the HMO is approved to provide access to Covered Services.

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

• **SHORT PROCEDURE UNIT**—a unit which is approved by the HMO and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient Stay in the absence of a Short Procedure Unit.

• **SKILLED NURSING FACILITY**—an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Substance Abuse and has contracted with the HMO to provide Covered Services to Members, 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 HMO.

• **SOUND NATURAL TEETH**—teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury/trauma, and are not man-made.

• **SPECIALIST SERVICES**—all physician services providing Medical Care or mental health care in any generally accepted medical or surgical specialty or subspecialty.

• **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.

• **STANDING REFERRAL (STANDING REFERRED)**—written documentation from the HMO that authorizes Covered Services for a life-threatening, degenerative or disabling disease or condition. The Covered Services will be rendered by the Referred Specialist named on the Standing Referral form. The Referred Specialist will have clinical expertise in treating the disease or condition.

  A Standing Referral must be issued to the Member prior to receiving Covered Services. The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid. Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

• **SUBSCRIBER**—the person who is eligible and is enrolled for coverage.
• **SUBSTANCE ABUSE**—any use of alcohol or other drugs which produces a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

• **SUBSTANCE ABUSE TREATMENT FACILITY**—a facility which is licensed by the Department of Health as an alcoholism or drug addiction treatment program that is primarily engaged in providing Detoxification and rehabilitation treatment for Substance Abuse.

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

• **THERAPY SERVICES**—the following services or supplies Prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Member:

  A. **Cardiac Rehabilitation Therapy**

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

  B. **Chemotherapy**

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

  C. **Dialysis**

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

  D. **Infusion Therapy**

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

  E. **Occupational Therapy**

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

Medically Prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception. Such dysfunction results from vision disorder, eye Surgery, or injury. Treatment involves a program which includes evaluation and training sessions.

G. Physical Therapy

Medically Prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

H. Pulmonary Rehabilitation Therapy

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

I. Radiation Therapy

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.

J. Speech Therapy

Medically Prescribed treatment of speech and language disorders due to disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

- **URGENT CARE**—Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or limb-threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Member’s health if treatment were delayed.
General Information

Other Coverage

Worker’s Compensation

Any benefits provided by Worker’s Compensation are not duplicated by the HMO.

Medicare

Effective January 1, 2007, any services paid or payable by Medicare when Medicare is (1) primary; or (2) would have been primary if the Member had enrolled for Medicare, are not duplicated by the HMO. For working Members over age 65, the primary payor will be determined in accordance with TEFRA or existing regulations regarding Medicare reimbursement.

NOTE: For more information regarding other coverage, see “Coordination of Benefits” and “Subrogation”.

Independent Corporation

The Group Contract is between the Group and Keystone. Keystone is a controlled affiliate of Independence Blue Cross operating under a license from Blue Cross and Blue Shield Association (the “Association”), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Keystone to use the familiar Blue Cross and Blue Shield words and symbols. Keystone, which is entering into the contract, is not contracting as an agent of the national Association. Only Keystone shall be liable to the Subscriber for any of the obligations as stated under the Group Master Contract. This paragraph does not add any obligations to the Contract.

If you have questions about any of the information in this Member Handbook, or need assistance at any time, please feel free to contact Member Services by calling the telephone number shown on the ID Card.
Self-Referred Benefits
Rider(s) and Booklet Certificate

SELF REFERRED BOOKLET CERTIFICATE........................................4.1–2
BENEFIT RIDER.................................................................4.2–2
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.
A COMPREHENSIVE MAJOR MEDICAL HEALTH BENEFITS
GROUP BOOKLET-CERTIFICATE

By and Between

QCC Insurance Company

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

And

[Account Name]
(Called "the Group")

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

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

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

ATTEST:

BY:

John R. Janney
Sr. Vice President
Marketing Services
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Important Notices</td>
<td>2</td>
</tr>
<tr>
<td>- Regarding Experimental/Investigative Treatment</td>
<td>2</td>
</tr>
<tr>
<td>- Regarding Treatment Which Is Not Medically Necessary</td>
<td>2</td>
</tr>
<tr>
<td>- Regarding Treatment For Cosmetic Purposes</td>
<td>2</td>
</tr>
<tr>
<td>- Regarding Coverage For Emerging Technology</td>
<td>2</td>
</tr>
<tr>
<td>Defined Terms</td>
<td>4</td>
</tr>
<tr>
<td>Schedule Of Benefits</td>
<td>17</td>
</tr>
<tr>
<td>Your Comprehensive Major Medical Health Benefits Plan</td>
<td>28</td>
</tr>
<tr>
<td>- Self-Referred Benefits</td>
<td>28</td>
</tr>
<tr>
<td>- Deductible</td>
<td>28</td>
</tr>
<tr>
<td>- Coinsurance</td>
<td>29</td>
</tr>
<tr>
<td>- Copayment</td>
<td>29</td>
</tr>
<tr>
<td>- Lifetime Maximum</td>
<td>29</td>
</tr>
<tr>
<td>- Payment of Benefits</td>
<td>29</td>
</tr>
<tr>
<td>Eligibility Under This Plan</td>
<td>31</td>
</tr>
<tr>
<td>- Eligible Person</td>
<td>31</td>
</tr>
<tr>
<td>- Eligible Dependent</td>
<td>31</td>
</tr>
<tr>
<td>Description Of Benefits</td>
<td>33</td>
</tr>
<tr>
<td>- Primary and Preventive Care</td>
<td>33</td>
</tr>
<tr>
<td>- Office Visits</td>
<td>33</td>
</tr>
<tr>
<td>- Pediatric Preventive Care</td>
<td>33</td>
</tr>
<tr>
<td>- Pediatric Immunizations</td>
<td>34</td>
</tr>
<tr>
<td>- Adult Preventive Care</td>
<td>34</td>
</tr>
<tr>
<td>- Routine Gynecological Examination, Pap Smear</td>
<td>34</td>
</tr>
<tr>
<td>- Mammograms</td>
<td>34</td>
</tr>
<tr>
<td>- Nutrition Counseling for Weight Management</td>
<td>34</td>
</tr>
<tr>
<td>Inpatient Benefits</td>
<td>34</td>
</tr>
<tr>
<td>- Hospital Services</td>
<td>34</td>
</tr>
<tr>
<td>- Medical Care</td>
<td>35</td>
</tr>
<tr>
<td>- Skilled Nursing Care Facility</td>
<td>36</td>
</tr>
<tr>
<td>Inpatient/Outpatient Benefits</td>
<td>36</td>
</tr>
<tr>
<td>- Blood</td>
<td>36</td>
</tr>
<tr>
<td>- Hospice Services</td>
<td>36</td>
</tr>
<tr>
<td>- Maternity/OB-GYN/Family Services</td>
<td>37</td>
</tr>
<tr>
<td>- Mental Health/Psychiatric Care</td>
<td>38</td>
</tr>
<tr>
<td>- Routine Costs Associated With Qualifying Clinical Trials</td>
<td>39</td>
</tr>
<tr>
<td>- Surgical Services</td>
<td>39</td>
</tr>
<tr>
<td>- Transplant Services</td>
<td>41</td>
</tr>
<tr>
<td>- Treatment for Alcohol or Drug Abuse and Dependency</td>
<td>41</td>
</tr>
<tr>
<td>Outpatient Benefits</td>
<td>42</td>
</tr>
<tr>
<td>- Ambulance Services</td>
<td>42</td>
</tr>
<tr>
<td>- Day Rehabilitation Program</td>
<td>43</td>
</tr>
<tr>
<td>- Diabetic Education Program</td>
<td>43</td>
</tr>
<tr>
<td>- Diabetic Equipment and Supplies</td>
<td>44</td>
</tr>
<tr>
<td>- Diagnostic Services</td>
<td>44</td>
</tr>
</tbody>
</table>

Form No. 16753-BC 1.09
Durable Medical Equipment ................................................................. 45
Emergency Care Services ........................................................................ 46
Home Health Care ................................................................................... 46
Injectable Medications ............................................................................. 47
Insulin and Oral Agents ............................................................................ 49
Medical Foods and Nutritional Formulas ................................................ 49
Non-Surgical Dental Services ................................................................... 49
Orthotics ................................................................................................. 49
Podiatric Care ........................................................................................ 49
Private Duty Nursing Services ............................................................... 50
Prosthetic Devices .................................................................................... 50
Specialist Office Visit ............................................................................. 51
Spinal Manipulative Services ................................................................... 51
Therapy Services ...................................................................................... 51

What Is Not Covered................................................................................... 53

General Information .................................................................................. 58
Benefits To Which You Are Entitled ............................................................. 58
Termination of Your Coverage and Conversion Privilege Under This Plan .................................................................................. 58
Termination of Coverage at Termination of Employment or Membership ........................................................................... 58
Continuation of Coverage and Termination of Employment or Membership
  Due to Total Disability ........................................................................... 59
Continuation of Incapacitated Child ............................................................. 59
When You Terminate Employment – COBRA ........................................... 59
Release of Information ............................................................................... 63
Consumer Rights ...................................................................................... 63
Limitation of Actions ................................................................................ 63
Claim Forms ............................................................................................. 64
Timely Filing ............................................................................................. 64
Covered Person/Provider Relationship ...................................................... 64
Subrogation ............................................................................................... 64
Coordination of Benefits .......................................................................... 64
BlueCard Program ...................................................................................... 66
Special Circumstances ............................................................................. 67

Managed Care ........................................................................................ 68
Utilization Review Process ...................................................................... 68
Clinical Criteria, Guidelines and Resources ................................................. 69
Delegation of Utilization Review Activities and Criteria ................................ 69
Precertification Review ........................................................................... 70
Inpatient Pre-Admission Review .............................................................. 70
Emergency Admission Review ............................................................... 71
Concurrent and Retrospective Review ..................................................... 71
Other Precertification Requirements ........................................................ 72
Services Requiring Precertification .......................................................... 73
Appeal Procedures .................................................................................. 75
INTRODUCTION

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

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

See "Important Notices".

And, read this booklet/certificate carefully.
IMPORTANT NOTICES

REGARDING EXPERIMENTAL/INVESTIGATIVE TREATMENT:

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

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY:

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

REGARDING TREATMENT FOR COSMETIC PURPOSES:

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

REGARDING COVERAGE FOR EMERGING TECHNOLOGY:

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

Form No. 16753-BC 2 1.09
REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of “Experimental/Investigative”, “cosmetic”, or “emerging technology”, the Covered Person, or his or her Provider, should contact the Carrier for a coverage determination. That way the Covered Person and the Provider will know in advance if the treatment will be covered by the Carrier.

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

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

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

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

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

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

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE – Complementary and alternative medicine, as defined by the National Institute of Health’s National Center for Complementary and Alternative Medicine (NCCAM), is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g. homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions which include a variety of techniques designed to enhance the mind’s capacity to affect bodily function and symptoms (e.g. meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance) (c) biologically based therapies using natural substances, such as herbs, foods, vitamins or nutritional supplements to prevent and treat illness. (e.g. diets, macrobiotics, megavitamin therapy); (d) manipulative and body-based methods (e.g. massage, equestrian/hippotherapy); and (e) energy therapies, involving the use of energy fields. The energy therapies are of two types: (1) Biofield therapies - intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi Gong, Reiki, and therapeutic touch. (2) Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the Carrier and which: A. Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis; B. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility; C. Does not provide Inpatient accommodations; and D. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

ANCILLARY PROVIDER – an individual or entity that provides services, supplies or equipment (such as, but not limited to, Infusion Therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under this Plan.
ANESTHESIA - consists of the administration of regional anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

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

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

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

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

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

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

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

COGNITIVE REHABILITATION THERAPY – Medically prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system insult (e.g. trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or re-establish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities which mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a physician, neuropsychologist, psychologist as well as a physical, occupational or speech therapist using a team approach.

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

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

COVERED EXPENSE - refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.
A. For services rendered by a Facility Provider, the term "Covered Expense" may not refer to the actual amount(s) paid by the Carrier to the Provider(s). Rather, "Covered Expense" means the following:
   1. For services rendered by a Participating Facility Provider, "Covered Expense" means the lesser of the actual charge and the amount payable to the Provider under the special pricing arrangement provided under the contractual arrangement in effect with the Carrier.
   2. For services rendered by a Non-Participating Facility Provider, "Covered Expense" means the lesser of the: (a) Facility Provider's charges, (b) Medicare Allowable Payment, or (c) Reasonable and Customary charge, for the Covered Services.

B. For services rendered by a Professional Provider, "Covered Expense" means the following:
   1. For 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 charge, or the charge, whichever is less.

C. For services rendered by Ancillary Providers, "Covered Expense" means the following:
   1. For services rendered by a Participating Ancillary Provider, "Covered Expense" means the amount negotiated with the Provider, or the charge, whichever is less;
   2. For services rendered by a Non-Participating Ancillary Provider, "Covered Expense" means the lesser of the: (a) Provider's charges, (b) Medicare Allowable Payment, or (c) Reasonable and Customary charge for the Covered Services.

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

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

**CUSTODIAL CARE** - provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

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

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

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

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

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

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

**EMERGENCY** - The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
A. Placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

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

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

**ENTERAL NUTRITION** - the provision of nutritional requirements into the alimentary tract.

**EXPERIMENTAL/INVESTIGATIVE** - a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:
A. Is the subject of ongoing Phase I or Phase II Clinical Trials;
B. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person’s particular condition;
D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person’s particular condition; or
E. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person’s particular condition, is recommended.

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

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

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

A. Ambulatory Surgical Facility
B. Birth Center
C. Free Standing Dialysis Facility
D. Free Standing Ambulatory Care Facility
E. Home Health Care Agency
F. Hospice
G. Hospital
H. Non-Hospital Facility
I. Psychiatric Hospital
J. Rehabilitation Hospital
K. Residential Treatment Facility
L. Short Procedure Unit
M. Skilled Nursing Facility

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

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

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

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

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

**HOME HEALTH CARE AGENCY** - a Facility Provider, approved by the Carrier, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of Treatment.
**HOSPICE** - a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

**HOSPITAL** - a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Carrier and which:

A. Is a duly licensed institution;
B. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
C. Has organized departments of medicine;
D. Provides 24-hour nursing service by or under the supervision of Registered Nurses;
E. Is not, other than incidentally, a: Skilled Nursing Facility; nursing home; Custodial Care home; health resort, spa or sanitarium; place for rest; place for aged; place for treatment of Mental Illness; place for treatment of Alcohol or Drug Abuse; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

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


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

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

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

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

**INTENSIVE OUTPATIENT PROGRAM** – planned, structured services comprised of coordinated and integrated multidisciplinary services designed to treat a patient often in crisis who suffers from Mental Illness, Serious Mental Illness or Alcohol or Drug Abuse/Dependency. Intensive Outpatient treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization Program treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until he is able to transition to less intensive outpatient treatment, as required.

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

**LICENSED PRACTICAL NURSE (LPN)** - a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.
**MAINTENANCE** - continuation of care and management of the Covered Person when the maximum therapeutic value of a Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, the provision of Covered Services for a condition ceases to be of therapeutic value and is no longer Medically Necessary. This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

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

A. **Benefit Maximum** - the greatest amount of a specific Covered Service that a Covered Person may receive.

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

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

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

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

**MEDICALLY NECESSARY** or **MEDICAL NECESSITY** shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**MEDICARE** - the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

**MEDICARE ALLOWABLE PAYMENT** - the payment amount, as determined by the Medicare program, for a Covered Service or supply.

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

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

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

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

**NON-PARTICIPATING PROVIDER** - an Ancillary Provider, Facility Provider, or Professional Provider that does not have a contractual relationship with the Carrier for the provision of Covered Services 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, Inpatient or Outpatient mental health/psychiatric care, or Copayment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the *Schedule of Benefits*.

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

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

**PARTIAL HOSPITALIZATION PROGRAM** – 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 (Intensive Outpatient Session or Outpatient office visit) but who does not require Inpatient confinement.

**PARTICIPATING ANCILLARY PROVIDER** – an Ancillary Provider that has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

**PARTICIPATING FACILITY PROVIDER** - a Facility Provider that has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

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

**PARTICIPATING PROVIDER** - an Ancillary Provider, Facility Provider, or Professional Provider that has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.
**PENALTY** - a type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified in the *Schedule of Benefits* and explained in detail in the *Managed Care* section.

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

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

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

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

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

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

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

**PRIMARY CARE PROVIDER** - a Professional Provider licensed where required and performing within the scope of such license in the following categories: General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, or Pediatrics.

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

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

- A. Audiologist
- B. Certified Registered Nurse
- C. Chiropractor
- D. Dentist
- E. Independent Clinical Laboratory
- F. Licensed Clinical Social Worker
- G. Master’s Prepared Therapist
- H. Nurse Midwife
- I. Optometrist
- J. Physical Therapist
- K. Physician
- L. Podiatrist
- M. Psychologist
- N. Registered Dietitian
- O. Speech-language Pathologist
- P. Teacher of the hearing impaired
**PROSTHETICS (or PROSTHETIC DEVICES)** – devices (except dental prosthetics), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

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

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

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

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

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

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

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

**REGISTERED DIETITIAN (RD)** - a dietitian registered by a nationally recognized professional association of dietitians. A Registered Dietitian (RD) is a food and nutrition expert who has met the minimum academic and professional requirements to qualify for the credential “RD.”

**REGISTERED NURSE (R.N.)** - a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.
REHABILITATION HOSPITAL - a Facility Provider, approved by the Carrier, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

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

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

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

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

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

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

SHORT PROCEDURE UNIT - a unit which is approved by the Carrier and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental illness, tuberculosis, or Alcohol or Drug Abuse, which:

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

SPECIALIST SERVICES – all services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.
SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

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

A. CARDIAC REHABILITATION THERAPY - medically supervised rehabilitation program designed to improve a Covered Person’s tolerance for physical activity or exercise.

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

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

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

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

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

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

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

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

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

TOTAL DISABILITY (or TOTALLY DISABLED) - means that a covered Employee, due to illness or injury, cannot perform any duty of his or her occupation or any occupation for which the Employee is, or may be, suited by education, training and experience, and the Employee is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Totally Disabled person must be under the regular care of a Physician.
URGENT CARE – Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or-limb threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Covered Person’s health if treatment were delayed.
SCHEDULE OF BENEFITS

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

The Covered Person will maximize the benefits available when Covered Services are provided by Participating Providers. The benefits of using these Providers include lower Coinsurance payments, no balance billing and no claim forms. The Your Comprehensive Major Medical Health Benefits Plan section provides more detail regarding these benefits.

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

<table>
<thead>
<tr>
<th>BENEFIT PERIOD</th>
<th>Calendar Year</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DEDUCTIBLE (Covered Person’s Responsibility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Person’s Deductible</td>
</tr>
<tr>
<td>Family Deductible</td>
</tr>
<tr>
<td>Deductible Carryover</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COINSURANCE (Covered Person’s Responsibility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% for Covered Services, except as otherwise specified in the Schedule of Benefits. For Treatment of Alcohol and Drug Abuse and Dependency services, in the first instance or course of treatment, no Deductible or Coinsurance shall be less favorable than those applied to similar classes or categories of treatment for physical illness.</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET LIMIT</strong></td>
</tr>
<tr>
<td><strong>LIFETIME MAXIMUM</strong></td>
</tr>
<tr>
<td><strong>REINSTATEMENT</strong></td>
</tr>
<tr>
<td>PRIMARY AND PREVENTIVE CARE</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>OFFICE VISITS</td>
</tr>
<tr>
<td>PEDIATRIC PREVENTIVE CARE</td>
</tr>
<tr>
<td>PEDIATRIC IMMUNIZATIONS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>ADULT PREVENTIVE CARE</td>
</tr>
<tr>
<td>ROUTINE GYNECOLOGICAL EXAMINATION, PAP SMEAR</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>MAMMOGRAMS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</td>
</tr>
<tr>
<td>Maximum of six (6) visits per Benefit Period.</td>
</tr>
</tbody>
</table>
### INPATIENT BENEFITS

#### HOSPITAL SERVICES

<table>
<thead>
<tr>
<th>Benefit Period Maximum: 70 Inpatient days.</th>
<th>The Plan pays: 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precertification required for all Inpatient admissions other than an admission for Emergency Care or Maternity Care.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
</tbody>
</table>

#### MEDICAL CARE

| The Plan pays: 50% |

#### SKILLED NURSING CARE FACILITY

<table>
<thead>
<tr>
<th>Benefit Period Maximum: 60 Inpatient days.</th>
<th>The Plan pays: 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precertification required for all Skilled Nursing Care Facility Inpatient admissions.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
</tbody>
</table>

### INPATIENT/OUTPATIENT BENEFITS

#### BLOOD

| The Plan pays: 50% |

#### HOSPICE SERVICES

<table>
<thead>
<tr>
<th>Respite Care: Maximum of 7 days every 6 months.</th>
<th>The Plan pays: 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precertification required for all Inpatient Hospice Services.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>INPATIENT/OUTPATIENT BENEFITS...Continued</strong></td>
<td><strong>The Plan pays:</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>MATERNITY/OB-GYN/FAMILY SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity/Obstetrical Care</strong></td>
<td></td>
</tr>
<tr>
<td>Professional Service</td>
<td>50%</td>
</tr>
<tr>
<td>Facility Service</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Elective Abortions</strong></td>
<td></td>
</tr>
<tr>
<td>Professional Service</td>
<td>50%</td>
</tr>
<tr>
<td>Facility Service</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Newborn Care</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Artificial Insemination</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH/PSYCHIATRIC CARE</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Treatment</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 20 Inpatient days.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Precertification required for all Mental Health/Psychiatric Care Inpatient admissions.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Treatment</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 20 Outpatient visits.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Precertification required for all Intensive Outpatient Program and Partial Hospitalization Program services.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Treatment for Serious Mental Illness</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 30 Inpatient days.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Precertification required for all Serious Mental Illness Inpatient admissions.</td>
<td></td>
</tr>
</tbody>
</table>
### INPATIENT/OUTPATIENT BENEFITS…Continued

<table>
<thead>
<tr>
<th>Service Description</th>
<th>The Plan pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Treatment for Serious Mental Illness</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 60 Outpatient visits.</td>
<td></td>
</tr>
<tr>
<td>Precertification required for all Intensive Outpatient Program and Partial Hospitalization Program services.</td>
<td></td>
</tr>
<tr>
<td>Each available Inpatient Treatment for Serious Mental Illness day may be exchanged for 2 additional Partial Hospitalization days/Outpatient Treatment sessions.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
<th>The Plan pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SURGICAL SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility Charges</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient Professional Charge</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient Anesthesia</td>
<td>50%</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>50%</td>
</tr>
<tr>
<td>Precertification required for certain Surgical Services.</td>
<td></td>
</tr>
<tr>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable for certain Surgical Services.</td>
<td></td>
</tr>
<tr>
<td>If more than 1 surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
<th>The Plan pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSPLANT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Charges</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient Facility Charges</td>
<td>50%</td>
</tr>
<tr>
<td>Precertification required for Transplant Services (except cornea).</td>
<td></td>
</tr>
<tr>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
<td></td>
</tr>
</tbody>
</table>
# INPATIENT/OUTPATIENT BENEFITS…Continued

<table>
<thead>
<tr>
<th>TREATMENT OF ALCOHOL OR DRUG ABUSE AND DEPENDENCY</th>
<th>The Plan pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Detoxification</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 7 days per admission.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Lifetime Maximum: 4 admissions.</td>
<td></td>
</tr>
</tbody>
</table>

Precertification required for all Inpatient Detoxification admissions.

| **Inpatient Treatment**                          | 50%           |
| Benefit Period Maximum: 30 Inpatient days.       | Failure to Precertify services will result in a 20% reduction in benefits payable. |
| Lifetime Maximum: 90 Inpatient days.             |               |

Precertification required for all Treatment of Alcohol or Drug Abuse Inpatient admissions.

| **Outpatient Treatment**                         | 50%           |
| Benefit Period Maximum: 60 Outpatient visits.    | Failure to Precertify services will result in a 20% reduction in benefits payable. |
| Lifetime Maximum: 120 Outpatient visits.         |               |

Precertification required for all Treatment of Alcohol or Drug Abuse Outpatient sessions.

30 Outpatient Treatment of Alcohol or Drug Abuse or Dependency days may be exchanged on a 2-to-1 basis for 15 additional days of Non-Hospital Residential Care.
<table>
<thead>
<tr>
<th>OUTPATIENT BENEFITS</th>
<th>The Plan pays:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBULANCE SERVICES</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency</td>
<td></td>
</tr>
<tr>
<td>Non-emergency</td>
<td>50%</td>
</tr>
<tr>
<td>Precertification required for Non-emergency Ambulance Services.</td>
<td>Failure to Precertify Non-emergency Ambulance services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>DAY REHABILITATION PROGRAM</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: Thirty (30) sessions.</td>
<td>Failure to Precertify Day Rehabilitation services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>DIABETIC EDUCATION PROGRAM</td>
<td>50%</td>
</tr>
<tr>
<td>Deductible and Maximum amounts do not apply.</td>
<td></td>
</tr>
<tr>
<td>DIABETIC EQUIPMENT AND SUPPLIES</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: $2,500.00 of Diabetic Equipment and Supplies</td>
<td></td>
</tr>
<tr>
<td>DIAGNOSTIC SERVICES</td>
<td></td>
</tr>
<tr>
<td>Routine Diagnostic/Radiology Services</td>
<td>50%</td>
</tr>
<tr>
<td>Non-Routine Diagnostic/Radiology Services</td>
<td>50%</td>
</tr>
<tr>
<td>(including MRI/MRA, CT scans, PET scans)</td>
<td></td>
</tr>
<tr>
<td>Precertification required for certain Non-Routine Diagnostic/Radiology Services.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Laboratory and Pathology Tests</td>
<td>50%</td>
</tr>
<tr>
<td>DURABLE MEDICAL EQUIPMENT</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: $2,500.00 of Durable Medical Equipment</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Precertification of supplies is required for items with a billed amount that exceeds $500 (includes replacements and repairs).</td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT BENEFITS</td>
<td>The Plan pays:</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>EMERGENCY CARE SERVICES</strong></td>
<td>100%, after a “Referred” Copayment. Refer to your member handbook/copayment schedule for copayment amount.</td>
</tr>
<tr>
<td><strong>HOME HEALTH CARE</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Precertification required for Home Health Care.</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>INJECTABLE MEDICATIONS</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Biotech/Specialty Injectables</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Precertification required for Biotech/Specialty Injectables.</td>
<td></td>
</tr>
<tr>
<td>Standard Injectables</td>
<td>50%</td>
</tr>
<tr>
<td><strong>INSULIN AND ORAL AGENTS</strong></td>
<td>100%</td>
</tr>
<tr>
<td>If this Plan does not provide coverage for prescription drugs, insulin and oral agents are covered less the applicable Copayment per prescription order:</td>
<td></td>
</tr>
<tr>
<td>Generic Copayment - $10</td>
<td>Brand Copayment - $15</td>
</tr>
<tr>
<td><strong>MEDICAL FOODS AND NUTRITIONAL FORMULAS</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>NON-SURGICAL DENTAL SERVICES</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Failure to Precertify Non-Surgical Dental Services will result in a 20% reduction in benefits payable.</td>
<td></td>
</tr>
<tr>
<td><strong>ORTHOTICS</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Precertification of supplies is required for items with a billed amount that exceeds $500 (includes replacement and repairs).</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>PODIATRIC CARE</strong></td>
<td>50%</td>
</tr>
<tr>
<td>OUTPATIENT BENEFITS</td>
<td>The Plan pays:</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>PRIVATE DUTY NURSING SERVICES</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 360 hours</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Precertification required for Private Duty Nursing Services.</td>
<td></td>
</tr>
<tr>
<td><strong>PROSTHETIC DEVICES</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Precertification of supplies is required for items with a billed amount that exceeds $500 (includes replacement and repairs).</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>SPECIALIST OFFICE VISITS</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>SPINAL MANIPULATION SERVICES</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 20 visits</td>
<td></td>
</tr>
<tr>
<td><strong>THERAPY SERVICES</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Therapy</td>
<td>Failure to Precertify services will result in a 20% reduction in benefits payable for Infusion Therapy.</td>
</tr>
<tr>
<td>Benefit Period Maximum: 36 sessions</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>50%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>50%</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>50%</td>
</tr>
<tr>
<td>Precertification required for certain Infusion Therapy Services.</td>
<td></td>
</tr>
<tr>
<td>Orthoptic/Pleoptic Therapy</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime Maximum: 8 sessions</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Therapy</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 36 sessions</td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT BENEFITS</td>
<td>The Plan pays:</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Physical Therapy/Occupational Therapy</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 30 sessions of Physical Therapy and Occupational Therapy combined</td>
<td></td>
</tr>
<tr>
<td>Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.</td>
<td></td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 20 sessions</td>
<td></td>
</tr>
</tbody>
</table>
YOUR COMPREHENSIVE MAJOR MEDICAL HEALTH BENEFITS PLAN

You (a Covered Person) can get the maximum benefits from your Comprehensive Major Medical Health Benefits Plan (this Plan) by using Participating Providers. The benefits of using these Participating Providers include:

- **Lower coinsurance payments.** When you use a Participating Provider, the Coinsurance you pay will be a percentage of the contracted rate. This rate is lower than what the Provider normally charges. If you use a Participating Facility Provider, 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; the Carrier has done it for you. This means less money out of your pocket.

- **No Balance Billing.** Participating Providers agree to accept the amount the Carrier pays, plus your Coinsurance. If you go to a Non-Participating Provider, the carrier will pay the applicable percentage of the Reasonable and Customary fee. You pay the balance of this amount; plus, if the Provider charges rates higher than those normally charged in the geographic area, you will pay the extra amount.

- **No Claim Forms.** When using a Participating Provider, you never have to fill out a claim form.

- **Precertification.** A list of services that require Precertification is shown in the Managed Care section of this booklet/certificate. If you are ever unsure over whether to Precertify, call the Carrier. Just use the toll-free number shown on your Identification Card.

A. **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 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 Precertified before you receive them, to determine whether they are Medically Necessary. Failure to Precertify Self-Referred Care services, when required, may result in a reduction of benefits. You will be financially liable for Penalties assessed for failure to Precertify Self-Referred Care benefits.

B. **DEDUCTIBLE**

You must Incur 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 and services to which the Deductible is applicable.

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

No more than three (3) times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. However, no family member may contribute more than the individual Deductible amount.
C. **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. See the *Schedule of Benefits* for specific Coinsurance amounts.

**Limits on Coinsurance Liability**

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

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

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

D. **LIFETIME MAXIMUM**

The Lifetime Maximum for benefits is shown in the *Schedule of Benefits*. Benefits will cease after benefits for care exceed the Lifetime Maximum. Amounts applied to the Covered Person’s Lifetime Maximum are not restorable.

E. **PAYMENT OF BENEFITS**

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

Participating Providers 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 Participating Provider. The Carrier will compensate a 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 Plan, or these Providers will, in most instances, submit claim forms for reimbursement on your behalf.

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

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 ninety (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 ninety (90) day period, your benefits will not be reduced, but in no event will the Carrier be required to accept the claim more than twelve (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.
ELIGIBILITY UNDER THIS PLAN

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

ELIGIBLE PERSON

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

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

ELIGIBLE DEPENDENT

Your family is eligible for coverage (Dependent coverage) under this Plan when you are eligible for Employee coverage. An eligible Dependent is defined as your spouse under a legally valid existing marriage, your unmarried child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. To determine the limiting age when coverage ends for covered, unmarried children, and students enrolled full-time in an Accredited Educational Institution, refer to your Keystone member handbook.

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

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

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

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

The newborn child(ren) of you or your Dependent shall be entitled to the benefits provided by this Plan from the date of birth for a period of thirty-one (31) days. Coverage of newborn children within such thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the thirty-one (31) day period, you must enroll the newborn child within such thirty-one (31) days. To continue coverage beyond thirty-one (31) days for a newborn child, who does not otherwise qualify for coverage as a Dependent, you must apply within thirty-one (31) days after the birth of the newborn and the appropriate rate must be paid when billed.
A newly acquired Dependent shall be eligible for coverage under this Plan on the date the Dependent is acquired provided that you apply to the Carrier for addition of the Dependent within thirty-one (31) days after the Dependent is acquired and you make timely payment of the appropriate rate. If Application is made later than thirty-one (31) days after the Dependent is acquired, coverage shall become effective on the first billing date following thirty (30) days after your Application is accepted by the Carrier.

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

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

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

The Covered Person will maximize the benefits available when Covered Services are provided by Participating Providers. The benefits of using these Providers include lower Coinsurance payments, no balance billing and no claim forms. The Your Comprehensive Major Medical Health Benefits Plan section provides more detail regarding these benefits.

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

PRIMARY AND PREVENTIVE CARE

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

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

The Carrier periodically reviews the schedule of Covered Services based on recommendations from national organizations of physicians, including pediatricians and internists; national independent panels of experts in primary care and prevention; national not-for-profit health organizations and government advisory panels. Accordingly, the frequency and eligibility of Covered Services are subject to change.

A. Office Visits

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

B. Pediatric and Adult Preventive Care

   Preventive Care services, including, but not limited to, periodic health assessments, well child care, routine physical examinations, and periodic gynecological examinations based on the recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of Covered Services are subject to change.
C. **Pediatric and Adult Immunizations**

Coverage will be provided for those pediatric and adult immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Pediatric immunization benefits are limited to Covered Persons under twenty-one (21) years of age.

D. **Routine Gynecological Examination, Pap Smear**

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

E. **Mammograms**

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

F. **Nutrition Counseling for Weight Management**

Coverage will be provided for any Covered Person for nutrition counseling visits in an office setting for the purpose of weight management, up to the Maximum visit limit as specified in the *Schedule of Benefits*.

**INPATIENT BENEFITS**

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

A. **Hospital Services**

1. **Ancillary Services**

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

2. **Room and Board**

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

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

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

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

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

B. **Medical Care**

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

1. **Concurrent Care**

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

2. **Consultations**

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

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

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

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

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

No Skilled Nursing Care Facility benefits are payable:

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

INPATIENT/OUTPATIENT BENEFITS

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

A. Blood

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

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

B. Hospice Services

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

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

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

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

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

C. Maternity/OB-GYN/Family Services

1. **Maternity/Obstetrical Care**

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

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

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

2. **Elective Abortions**

   Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Covered Person are a Covered Expense under this Plan.

3. **Newborn Care**

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

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

D. **Mental Health/Psychiatric Care**

Benefits for the treatment of Mental Illness and Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as Mental Health/Psychiatric Care are subject to the Mental Health/Psychiatric Care limitations shown in the Schedule of Benefits. Precertification must be obtained for all Inpatient treatment, Intensive Outpatient Program and Partial Hospitalization Program services, other than Emergency Care, in order to assure the Medical Necessity of the proposed treatment based on the nature and severity of the Covered Person’s condition. When a Provider renders Medical Care, other than Mental Health/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 and will not be subject to the Mental Health/Psychiatric Care limitations.

1. **Inpatient Treatment**

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

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

2. **Outpatient Treatment**

Benefits are provided, subject to the Benefit Period limitations shown in the Schedule of Benefits, for Outpatient treatment of Mental Illness and Serious Mental Illness. Outpatient mental health/psychiatric services shall be covered for the full number of Outpatient session visits or an equivalent number of Intensive Outpatient Program or Partial Hospitalization Program visits per Benefit Period. For treatment of Mental Illness the Covered Person may trade off: (a) on a one (1) for two (2) basis, Inpatient days for additional separate Intensive Outpatient Program or Partial Hospitalization Program services; or (b) on a one (1) for four (4) basis, Inpatient days for additional Outpatient visits. See the Schedule of Benefits for limits on the number of Inpatient days that may be exchanged in any Benefit Period. For treatment of Serious Mental Illness, the Covered Person may trade on a one (2) for two (2) basis, Inpatient days for additional Intensive Outpatient Program or Partial Hospitalization Program/Outpatient session visits. All Intensive Outpatient Program and Partial Hospitalization Program services must be pre-certified by the Carrier.

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

3. **Benefits are not payable for the following services:**

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

4. **Benefit Period Maximums for Mental Health/Psychiatric Care**

   All Inpatient and Outpatient Mental Health/Psychiatric Care for both Mental Illness and Serious Mental Illness are covered up to the Maximum day and visit limitation amounts per Benefit Period specified in the *Schedule of Benefits*. The Benefit Period Inpatient day and Outpatient visit limitation amounts for Serious Mental Illness are separate from, not aggregate of, the Inpatient day and Outpatient visit limitation amounts for all other Mental Health/Psychiatric Care other than Serious Mental Illness.

E. **Routine Costs Associated With Qualifying Clinical Trials**

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

F. **Surgical Services**

   Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Also covered is: (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for: (1) the surgical procedure performed in connection with the initial and subsequent, insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (2) the treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedema is not subject to any benefit Maximum amounts that apply to “Physical Therapy” services” as provided under subsection entitled “Therapy Services”.

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

1. **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 Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the “Oral Surgery” terms of this booklet/certificate will be covered during such a confinement.
2. **Oral Surgery**

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

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

   1. The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.
   2. In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
   3. In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.

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

   1. Surgical removal of impacted teeth which are partially or completely covered by bone;
   2. The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
   3. Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

3. **Assistant at Surgery**

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

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. **Anesthesia**

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

5. **Second Surgical Opinion (Voluntary)**

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

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

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

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

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

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

H. **Treatment for Alcohol or Drug Abuse and Dependency**

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

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and dependency provided by a Hospital or Facility Provider, subject to the Maximums shown in the Schedule of Benefits, according to the provisions outlined below.

1. **Inpatient Treatment**
   a. **Inpatient Detoxification**

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

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

   b. **Hospital and Non-Hospital Residential Treatment**

   Hospital or Non-Hospital Residential Treatment of Alcohol or Drug Abuse and dependency shall be covered on the same basis as any other illness covered under this Plan, but services are limited to thirty (30) days per Benefit Period.
The lifetime maximum number of days per covered person for this benefit is shown in the Schedule of Benefits.

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

2. **Outpatient Treatment**

Outpatient alcohol or drug services shall be covered for sixty (60) full outpatient session visits or an equivalent number of partial hospitalization visits per benefit period. Thirty (30) of the sixty (60) separate sessions of outpatient or partial hospitalization services may be exchanged on a two (2) to one (1) basis to receive up to fifteen (15) more days of non-hospital residential alcohol or drug abuse treatment (i.e., the covered person may trade off on a two (2) for one (1) basis up to thirty (30) separate sessions of outpatient services per benefit period in order to receive up to fifteen (15) additional days of hospital and non-hospital residential alcohol or drug abuse treatment days). Any benefits exchanged or traded off under terms of this provision are subject to, and do not increase, the overall lifetime maximum.

The lifetime maximum number of days per covered person for this benefit is shown in the Schedule of Benefits.

Covered services include:
- Diagnosis and treatment of substance abuse, including outpatient detoxification;
- Physician, psychologist, nurse, certified addictions counselor and trained staff services;
- Rehabilitation therapy and counseling;
- Family counseling and intervention;
- Psychiatric, psychological and medical laboratory testing;
- Drugs, medicines, use of equipment and supplies.

**Outpatient Benefits**

A covered person is entitled to benefits for covered services on an outpatient basis when deemed medically necessary and billed for by a provider. Payment allowances for covered services and any precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

**A. Ambulance Services**

Benefits are provided for ambulance services that are medically necessary, as determined by the carrier, for transportation in a specially designed and equipped vehicle used only to transport the sick or injured, but only when:

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

Form No. 16753-BC  1.09
Benefits are payable for air or sea transportation only if the patient's condition, and the distance to the nearest facility able to treat the Covered Person's condition, justify the use of an alternative to land transport.

1. **For Emergency Ambulance transport:**

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

2. **For Non-Emergency Ambulance transport:**

   All non-emergency ambulance transports must be Precertified by the Carrier to determine Medically Necessary which includes specific origin and destination requirements specified in the Company’s policies.

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

**B. Day Rehabilitation Program**

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

1. The Covered Person requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five (5) days per week for 4-7 hours per day;
2. The Covered Person has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;
3. The Covered Person is willing to participate in a Day Rehabilitation Program; and
4. The Covered Person’s family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

**C. Diabetic Education Program**

Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a Professional Provider legally authorized to prescribe such items under law.

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

Outpatient diabetic education services will be covered when provided by a Participating Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Carrier. These requirements are based on the certification programs for Outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.
Covered services include Outpatient sessions that include, but may not be limited to, the following information:

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

D. **Diabetic Equipment and Supplies**

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

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

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

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

E. **Diagnostic Services**

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

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

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

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

F. **Durable Medical Equipment**

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

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

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

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

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

1. **Comfort and convenience items**, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.
2. **Equipment used for environmental control**, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.
3. **Equipment inappropriate for home use**. This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, transflect chairs and traction units.
4. **Non-reusable supplies** other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment. Items not covered include, but are not limited to, incontinence pads, lambs wool pads, ace bandages, antiembolism stockings, catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits.
5. **Equipment that is not primarily medical in nature**. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered “medical” in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to, ear plugs, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils, toileting systems, electronically-controlled heating and cooling units for pain relief, toilet seats, bathtub lifts, stairglides, and elevators.
6. **Equipment with features of a medical nature** which are not required by the Covered Person’s condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly
disproportionate to its cost, if there exists a Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.

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

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

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

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

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

G. **Emergency Care Services**

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

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

H. **Home Health Care**

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

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

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

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

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

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

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

For purposes of this Home Health Care benefit, the following definitions apply:

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

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

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

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

### I. Injectable Medications

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

1. **Biotech/Specialty Injectables**

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

**Biotech/Specialty Injectables:**
- **Anticoagulant/Low Molecular Weight Heparin Agents:** Arixtra, Fragmin, Innohep, Lovenox,
- **Antiretroviral Agents** Fuzeon
- **Botulinum Toxin Agents** Botox, Myobloc
- **Central Nervous System Agents** Apokyn, Imitrex, Vivitrol
- **Endocrine/Metabolic Agents** Eligard, Faslodex, Forteo, Lupron, Sandostatin, Somatuline Depot, Somavert, Somatuline LA, Thyrogen, Trelstar, Vantas, Viadur, Zoladex
- **Growth Hormones and related agents**
  - Genotropin, Humatrope, Increlex, Norditropin, Nutropin/Nutropin AQ, Omnitrope,
  - Saizen, Serostim/Serostim LQ, Tev-Tropin, Zorbive
- **Hematopoietic Agents**
  - Aranesp, Epogen, Leukine, Neulasta, Neumega, Neupogen, Procrit
- **Hepatitis/Interferon Alfa Agents**
  - Actimmune, Alferon N, Infergen, Intron A, Pegasys, PEG Intron, Roferon-A
- **Hyaluronate Agents**
  - Euflexxa, Hyalgan, Orthovisc, Supartz, Synvisc
- **Immunological Modifiers**
  - Amevive, Enbrel, Humira, Kineret, Raptiva
- **Intra-Ocular Agents**
  - Lucentis, Macugen, Vitrasert
- **Multiple Sclerosis Agents/Interferon Beta Agents**
  - Avonex, Betaseron, Copaxone, Rebif
- **Respiratory Agents**
  - Synagis, Xolair

**THIS LIST IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.**

2. **Standard Injectables**

Refers to all other injectable medications including, but not limited to, allergy injections and extractions and injectable medications only administered in a Physician’s office such as antibiotic and steroid injections.
J. **Insulin and Oral Agents**

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

K. **Medical Foods and Nutritional Formulas**

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

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

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

L. **Non-Surgical Dental Services**  
*(Dental Services as a Result of Accidental Injury)*

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

M. **Orthotics**

Benefits are provided for:

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

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

N. **Podiatric Care**

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

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

Benefits are not payable for:

1. Nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;
2. Services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family; and
3. Services provided by a home health aide or a nurse's aide.

P. Prosthetic Devices

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

Such expenses may include, but not be limited to:

1. The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
3. Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive surgery incident and subsequent to mastectomy;
4. Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
   a. Initial contact lenses prescribed for treatment of infantile glaucoma;
   b. Initial pinhole glasses prescribed for use after surgery for detached retina;
   c. Initial corneal or scleral lenses prescribed (1) in connection with the treatment of keratoconus; or (2) to reduce a corneal irregularity other than astigmatism;
   d. Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
   e. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of (1) Accidental Injury; (2) trauma, or (3 ocular surgery.

Benefits are not provided for:

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

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

Benefits for replacement of a Prosthetic Device or its parts will be provided: (a) when there has been a significant change in the Covered Person’s medical condition that requires the replacement, (b) if the prostheses breaks because it is defective, or (c) if the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer, or (d) for a Dependent child due to the normal growth process when Medically Necessary.
The Carrier will provide benefits to repair Prosthetic Devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of a prosthesis, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Carrier will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

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

Q. Specialist Office Visit

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

R. Spinal Manipulation Services

Benefits shall be provided up to the limits specified in the Schedule of Benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

S. Therapy Services

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

1. Cardiac Rehabilitation Therapy

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

2. Chemotherapy

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes). The cost of drugs, approved by the Federal Food and Drug Administration (FDA) and only for those uses for which such drugs have been specifically approved by the FDA as antineoplastic agents is covered, provided they are administered as described in this paragraph.

3. Dialysis

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

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

5. **Occupational Therapy**

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

6. **Orthoptic/Pleoptic Therapy**

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

7. **Pulmonary Rehabilitation Therapy**

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

8. **Physical Therapy**

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

9. **Radiation Therapy**

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

10. **Speech Therapy**

Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.
WHAT IS NOT COVERED

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

- Which are not Medically Necessary as determined by the Carrier for the diagnosis or treatment of illness or injury;

- Which are Experimental/Investigative in nature;

- Which were Incurred prior to the Covered Person's effective date of coverage;

- Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the General Information section;

- For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;

- For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;

- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

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

- For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;

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

- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;

- Which are not billed and performed by a Provider as defined under this coverage as a “Professional Provider”, “Facility Provider” or “Ancillary Provider” except as otherwise indicated under the subsections entitled: (a) “Therapy Services” (that identifies covered therapy services as provided by licensed therapists), and (b) “Ambulance Services” in the Description of Benefits section of this booklet/certificate;

- Rendered by a member of the Covered Person's Immediate Family;

- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;

- For ambulance services except as specifically provided under this Plan;
• For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for and defined in the “Surgical Services” section in the Description of Benefits;

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

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

• For marriage counseling;

• For Custodial Care, domiciliary care or rest cures;

• For equipment costs related to services performed on high cost technological equipment as defined by the Carrier, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Carrier;

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

• For dental implants for any reason;

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

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

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

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

• For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and pediatric appliances required for the prevention of complications associated with diabetes;
• For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;

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

• For treatment of obesity, except for surgical treatment when: (a) the Carrier determines the surgery is Medically Necessary, and (b) the surgery is not a repeat, reversal or revision of any previous obesity surgery. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure is required to treat complications which, if left untreated, would result in endangering the health of the Covered Person. This exclusion does not apply to nutrition visits as set forth in the Description of Benefits section under the subsection entitled "Nutrition Counseling for Weight Management";

• For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

• For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

• For weight reduction and premarital blood tests. This exclusion does not apply to nutrition visits as set forth in the Description of Benefits section under the subsection entitled "Nutrition Counseling for Weight Management";

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

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

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

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

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

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

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

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

• For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits;
• For prescription drugs, except as may be provided by a prescription drug rider attached to this booklet/certificate. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;

• For contraceptives;

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

• For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentum, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the “Medical Foods and Nutritional Formulas” section in the Description of Benefits;

• For Inpatient Private Duty Nursing services;

• For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;

• For Maintenance of chronic conditions;

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

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

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

• For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;

• For Hearing Aids, including cochlear electromagnetic devices, or hearing examinations or tests for the prescription or fitting of Hearing Aids, except as may be provided by a Hearing Aids benefit rider attached to this booklet/certificate;

• For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT), except as may be provided by an assisted fertilization benefits rider attached to this booklet/certificate;

• For cranial prostheses, including wigs intended to replace hair, except as may be provided by a wig benefit rider attached to this booklet/certificate;

• For any Surgery performed for the reversal of a sterilization procedure;
For any other service or treatment, except as provided under this Plan, 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 Plan. Any Copayment or Deductible amounts required by the Keystone HMO contract are also excluded.
GENERAL INFORMATION

A. BENEFITS TO WHICH YOU ARE ENTITLED

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

B. TERMINATION OF YOUR COVERAGE AND CONVERSION PRIVILEGE UNDER THIS PLAN

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

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

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

The privilege of conversion is available for you and your eligible Dependents except in the following circumstances:
1. The Group terminates this Plan in favor of group coverage by another organization; or
2. The Group terminates the Covered Person in anticipation of terminating this Plan in favor of group coverage by another organization.

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

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

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

C. TERMINATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP IN THE GROUP

When a Covered Person ceases to be an eligible Employee or eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which
payment was made. However, if benefits under this Plan are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person’s termination under this Plan, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under this Plan to be not more than sixty (60) days before the first day of the month in which the Group notified the Carrier of such termination.

D. CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY

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

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

E. CONTINUATION OF INCAPACITATED CHILD

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you (an enrolled Employee) for over half of his support, you may apply to the Carrier to continue coverage of such child under this Plan upon such terms and conditions as the Carrier may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a dependent and mental or physical incapacity commenced prior to age twenty-five (25).

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

F. WHEN YOU TERMINATE EMPLOYMENT - CONTINUATION OF COVERAGE PROVISIONS – CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED (COBRA)

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

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

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

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 eighteen (18) months, if:
1. Your termination of employment was not due to gross misconduct; and
2. You are not entitled to Medicare.

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

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

To elect the extra eleven (11) months of continuation, the plan administrator must be given written proof of Social Security’s determination of the qualified beneficiary’s disability before the earlier of:
1. The end of the eighteen (18) month continuation period; and
2. Sixty (60) days after the date the qualified beneficiary is determined to be disabled.

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

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

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

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

If you become entitled to Medicare before terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to eighteen (18) months, but may be extended until thirty-six (36) months from the date you became entitled to Medicare, subject to the “When Continuation Ends” paragraph of this subsection.
If a Dependent Loses Eligibility: If your Dependent child’s group health benefits end due to his or her loss of dependent eligibility as defined in this booklet/certificate, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to thirty-six (36) months, subject to the “When Continued Ends” paragraph of this subsection.

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

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

The Qualified Beneficiary’s Responsibilities: A person eligible for continuation under this subsection must notify the plan administrator, in writing, of:
1. Your divorce or legal separation from your spouse;
2. Your Dependent child's loss of Dependent eligibility, as defined in this booklet/certificate; or

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

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

The Employer’s Responsibilities: Your employer must notify the plan administrator, in writing, of:
1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your death;
3. Your entitlement to Medicare; or
4. Commencement of Employer’s bankruptcy proceedings.

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

The Plan Administrator’s Responsibilities: The plan administrator must notify the qualified beneficiary, in writing, of:
1. His or her right to continue the group health benefits described in this booklet/certificate;
2. The monthly premium he or she must pay to continue such benefits; and
3. The times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within fourteen (14) days of:
1. The date the employer notifies the plan administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
2. The date the qualified beneficiary notifies the plan administrator, in writing, of your divorce or legal separation from your spouse, or your Dependent child's loss of eligibility.
The Employer’s Liability: Your employer will be liable for the qualified beneficiary’s continued group health benefits to the same extent as, and in the place of, the Carrier, if:
1. The plan administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above; or
2. The employer fails to remit a qualified beneficiary’s timely premium payment to the Plan on time, hereby causing the qualified beneficiary’s group health benefit to end.

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

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

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

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

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

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

When Continuation Ends: A qualified beneficiary’s continued group health benefits under this Plan ends on the first to occur of the following:
1. With respect to continuation upon your termination of employment or reduction of work hours, the end of the eighteen (18) month period which starts on the date the group health benefits would otherwise end;
2. With respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional eleven (11) months of continuation, the earlier of:
   a. The end of the twenty-nine (29) month period which starts on the date the group health benefits would otherwise end; or
   b. The first day of the month which coincides with or next follows the date which is thirty (30) days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;
3. With respect to continuation upon your death, your divorce or legal separation, or the end of your covered Dependent’s eligibility, the end of the thirty-six (36) month period which starts on the date the group health benefits would otherwise end;
4. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare, after your termination of employment or reduction of work hours, the end of the thirty-six (36) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
b. Before, your termination of employment or reduction of work hours where, during the eighteen (18) month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the eighteen (18) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than thirty-six (36) months from the date you become entitled to Medicare.

5. The date coverage under this Plan ends;
6. The end of the period for which the last premium payment is made;
7. The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
8. The date he or she becomes entitled to Medicare.

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

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

G. RELEASE OF INFORMATION

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

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

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

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

H. CONSUMER RIGHTS

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

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

I. LIMITATION OF ACTIONS

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

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

K. **TIMELY FILING**

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

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

L. **COVERED PERSON/PROVIDER RELATIONSHIP**

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

M. **SUBROGATION**

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

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

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

N. **COORDINATION OF BENEFITS**

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

1. **Definitions**

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

   "Plan" shall mean any group arrangement providing health care benefits or Covered Services through:
   a. Individual, group, (except hospital indemnity plans of less than $200), blanket (except student accident) or franchise insurance coverage;
   b. The Plan, health maintenance organization and other prepayment coverage;
c. Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and

d. Coverage under any tax supported or government program to the extent permitted by law.

2. **Determination of Benefits**

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

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

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

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

   b. If the other Plan includes rules for coordinating benefits:

      1. The Plan covering the patient other than as a Dependent shall be primary.

      2. The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. However, if the other Plan does not have the birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child's parents are separated or divorced.

      3. Except as provided in subparagraph (4) below, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:

         i. First, the Plan covering the child as a Dependent of the parent with custody;

         ii. Then, the Plan of the spouse of the parent with custody of the child;

         iii. Finally, the Plan of the parent not having custody of the child.

      4. When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.

      5. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in 2.b.(2).

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

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

3. **Effect on Benefits**

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

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

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

**Right of Recovery**

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

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

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

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

O. **BLUECARD PROGRAM**

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

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

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

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

P. SPECIAL CIRCUMSTANCES

In the event that Special Circumstances result in a severe impact to the availability of providers and services, or to the procedures required for obtaining benefits for Covered Services under this coverage (e.g., obtaining Precertification, use of Participating or Member Providers), or to the administration of this benefit program by the Carrier, the Carrier may on a selective basis, waive certain procedural requirements of this coverage. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Carrier shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Carrier nor Member and Participating Providers shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances, as recognized in the community, and by the Carrier and appropriate regulatory authority, are extraordinary circumstances not within the control of the Carrier, including but not limited to: (a) major disaster; (b) epidemic; (c) pandemic; (d) the complete or partial destruction of facilities; (e) riot; or (f) civil insurrection.
A. UTILIZATION REVIEW PROCESS

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

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

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

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

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

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

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

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

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


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

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

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

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

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

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

**Utilization Review and Criteria for Mental Health/Substance Abuse Services**

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

**D. PRECERTIFICATION REVIEW**

When required, Precertification review evaluates the Medical Necessity, including the Medical Necessity of the setting, of proposed services for coverage under the Covered Person’s benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. Where Precertification review is required, the Carrier’s coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

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

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

**1. INPATIENT PRE-ADMISSION REVIEW**

In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Carrier as to the Medically Necessary of the admission. The Precertification requirements for Emergency admissions are set forth in the “Emergency Admission Review” subsection of this Managed Care section. The Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact the Carrier prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Carrier will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits as shown in the Schedule of Benefits if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet/certificate.

If such prior approval for a Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown in the Schedule of Benefits, will be deemed not to be Covered Services under this coverage. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.
If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

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

The Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for admissions to Participating Hospitals which fail to conform to the above pre-admission certification requirements unless: (a) the Hospital provides prior written notice that the admission will not be paid by the Carrier; and (b) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Hospital admission.

2. **EMERGENCY ADMISSION REVIEW**

Covered Persons are responsible for notifying the Carrier of an Emergency admission 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 Covered Expense. Such penalty, as shown in the Schedule of Benefits, will be the sole responsibility of, and payable by, the Covered Person.

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

3. **CONCURRENT AND RETROSPECTIVE REVIEW**

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent Review is generally not performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with the Facility does not require such review.

Retrospective/Post Service review:

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

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

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

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

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

**E. OTHER PRECERTIFICATION REQUIREMENTS**

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

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

The Covered Person is responsible to have the Provider performing the service contact the Carrier to initiate Precertification. The Carrier will verify the results of the Precertification with the Covered Person and the Provider.

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

The following services must be Precertified.

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

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

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

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

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

6. INFUSION THERAPY

1. Infusion Therapy in a home setting
2. Infusion Therapy in an Outpatient Facility or office setting (except cancer Chemotherapy, whole blood and blood plasma). Drugs listed below that are given by Infusion Therapy when such Infusion Therapy is provided in an Outpatient Facility or in a Professional Provider’s Office.

IMPORTANT: THE LIST OF INFUSION DRUGS LISTED BELOW IS SUBJECT TO PRECERTIFICATION. THIS LIST IS SUBJECT TO CHANGE AS NEW INFUSION DRUGS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON THE IDENTIFICATION CARD.

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

* Infusion drugs that are newly approved by the FDA during the effective term of the Group Contract are considered new and emerging technology and will be subject to Precertification.

7. BIOTECH/SPECIALTY INJECTABLE DRUGS (see list under “Biotech/Specialty Injectables” in Description of Benefits)

IMPORTANT: THIS LIST OF BIOTECH/SPECIALTY MEDICATION PRECERTIFICATION REQUIREMENTS IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.

In addition to the Precertification requirements listed above, the Covered Person should contact the Carrier for certain categories of treatment (listed below) so that the Covered Person will know prior to receiving treatment whether it is a Covered Service. Those categories of treatment (in any setting) include:

1. Any surgical procedure that may be considered potentially cosmetic;
2. Any procedure, treatment, drug or device that represents “emerging technology”, and
3. Services that might be considered Experimental/Investigative.

The Covered Person’s Provider should be able to assist in determining whether a proposed treatment falls into one (1) of these three (3) categories. Also, the Carrier encourages the Covered Person’s Provider to place the call for the Covered Person.
For more information, please see the *Notices* placed in the front pages of this booklet/certificate that pertain to Experimental/Investigative services, Cosmetic services, Medically Necessary services and Emerging Technology.

G. **APPEAL PROCEDURE**

Refer to the Keystone Member Handbook for a description of appeal procedures.
AMENDMENT TO YOUR COMPREHENSIVE MAJOR MEDICAL AGREEMENT

QCC INSURANCE COMPANY

This Notice of Change is issued to form part of your Booklet/Certificate that describes QCC Insurance Company’s Comprehensive Major Medical Health Care Program (Form Nos. 16753.BC and 16761.BC).

This Notice changes the language that describes the provisions, conditions or other terms of the Booklet/Certificate as detailed below.

Effective January 1, 2011:

I. The Defined Terms section is revised as follows:

1. The Defined Terms section is expanded to include the following terms:

   **SPECIALTY DRUG** – A medication that meets certain criteria including, but not limited to:
   
   - The drug is used in the treatment of a rare, complex, or chronic disease (e.g., hemophilia).
   - A high level of involvement is required by a healthcare provider to administer the drug.
   - Complex storage and/or shipping requirements are necessary to maintain the drug’s stability.
   - The drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance.
   - Access to the drug may be limited.

   **STANDARD INJECTABLE DRUG** – A medication that is either injectable or infusible but is not defined by the company to be a Self-Injectable Drug or a Specialty Drug. Standard Injectable Drugs include, but are not limited to: allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.

2. The following terms are replaced by the following:

   **DETOXIFICATION** – The process by which an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a licensed Facility Provider, or in case of opiates, by an appropriately licensed behavioral health provider in an ambulatory setting. This treatment process will occur 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 and psychological risk to the patient at a minimum.

   **INFUSION THERAPY** - Treatment including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration by a healthcare provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the member. The type of healthcare provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the company.
**PENALTY** - a type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified and explained in detail in the *Managed Care* section.

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

A. Investigates a service that falls within a benefit category of this Plan;
B. Is not specifically excluded from coverage;
C. Based on currently available scientific information, the drug, biological product, device, medical treatment, therapy or procedure being studied may be of benefit in treating the disease or condition for which the drug, biological product, device, medical treatment, therapy or procedure is being prescribed.
D. The member is a subject enrolled in a phase II, III, or IV clinical trial or a phase I cancer clinical trial
E. Does not duplicate existing studies;
F. Is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;
G. Is designed and conducted according to appropriate standards of scientific integrity;
H. Complies with Federal regulations relating to the protection of human subjects;
I. Has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;
J. Is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or (2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;
K. Is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider.

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

II. The *Schedule of Benefits* section is revised as follows:

1. The third paragraph of the introductory section is revised to read:

Some Covered Services must be Precertified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medically Necessary of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the *Managed Care* section. Covered Services that require Precertification, and any Penalty for failure to obtain a Precertification, are specified in the *Managed Care*. Failure to obtain precertification will result in a 20% reduction in benefits.
2. All references to Precertification requirements and Penalty information that follow the introductory paragraphs are removed from this section.

3. The references to Biotech / Specialty Injectables and Standard Injectables are replaced by Specialty Drug and Standard Injectable Drugs respectively.

III. The Precertification bulleted item under the **Your Comprehensive Major Medical Health Benefits Plan** section is replaced by the following:

- **Precertification.** To obtain a list of services that require Precertification please follow the instructions found in the *Managed Care* section of this booklet/certificate. If you are ever unsure over whether to Precertify, **call the Carrier.** Just use the toll-free number shown on your Identification Card.

IV. The **Description of Benefits** section is revised as follows:

1. The third paragraph of the Description of Benefits section is revised to read:

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

2. All references to Precertification requirements and Penalty information that follow the introductory paragraphs are removed from this section.

3. Item 2.a of the Outpatient subsection of the Treatment for Alcohol or Drug Abuse and Dependency section is replaced by the following:

   a) Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification by the appropriately licensed behavioral health provider;

4. Item 2.f of the Outpatient subsection of the Treatment for Alcohol or Drug Abuse and Dependency section is replaced by the following:

   f) Medication management and use of equipment and supplies

5. The first paragraph of the Diabetic Equipment and Supplies section is replaced by the following:

   Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits. If this Plan provides benefits for prescription drugs (other than coverage for insulin and oral agents only), certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy if available, subject to the cost-sharing arrangements applicable to the prescription drug coverage. Certain diabetic equipment is not available at a pharmacy. In these instances the diabetic equipment will be provided under the Durable

16753_16761_be_blc8
Medical Equipment benefit subject to the cost-sharing arrangements applicable to Durable Medical Equipment.

6. Item 1. of the Injectable Medications section is replaced by the following:

1. **Specialty Drugs**

   Specialty Drugs refer to a medication that meets certain criteria including, but not limited to: the drug is used in the treatment of a rare, complex, or chronic disease (e.g., hemophilia); a high level of involvement is required by a healthcare provider to administer the drug; complex storage and/or shipping requirements are necessary to maintain the drug’s stability; the drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance and access to the drug may be limited. To obtain a list of Specialty Drugs please logon to www.ibxpress.com or call the Customer Service telephone number listed on the back of your identification card. The purchase of all Specialty Drugs is subject to the Coinsurance percentage if dispensed by a Non-Participating Provider. The Coinsurance amount is shown in the Schedule of Benefits. The Coinsurance will apply: (a) to each thirty (30) day supply of medication dispensed for medications administered on a regularly scheduled basis; or (b) to each course/series of injections if administered on an intermittent basis. A ninety (90) day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness.

7. Item 2. of the Injectable Medications section is replaced by the following:

2. **Standard Injectable Drugs**

   a. Standard Injectable Drugs refer to a medication that is either injectable or infusible but is not defined by the company to be a Self-Injectable Drug or a Specialty Drug. Standard Injectable Drugs include, but are not limited to: allergy injections and extractions and injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.

   b. Self-Injectable Drugs generally are not covered. For more information on Self-Injectable Prescription Drugs (Self-Injectable Drugs), please refer to the What Is Not Covered section and the description of Insulin and Oral Agents coverage in the Description of Benefits section.

8. The Infusion Therapy subsection of the Therapy Services section is replaced by the following:

   **Infusion Therapy**

   Treatment including, but not limited to, infusion or inhalation, parenteral and enteral nutrition, antibiotic therapy, pain management, hydration therapy, or any other drug that requires administration by a healthcare provider. Infusion therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the member. The type of healthcare provider who can administer the infusion depends on whether the drug is
considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the company.

V. The following exclusions in the What Is Not Covered section are replaced by the following:

- For treatment of obesity, except for surgical treatment of obesity when the Carrier (a) determines the surgery is Medically Necessary; and (b) the surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the Carrier or another carrier. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person. This exclusion does not apply to nutrition visits as set forth in the Description of Benefits section under the subsection entitled "Nutrition Counseling for Weight Management";

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

VI. Item P. BLUECARD PROGRAM of the General Information section is replaced by the following:

P. BlueCard Program

I. Out-of-Area Services

QCC Insurance Company (“QCC”) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of QCC service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between QCC and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the QCC service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers. QCC payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, QCC will remain responsible for fulfilling QCC contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.
Whenever you access covered healthcare services outside QCC’s service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to QCC.

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

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

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

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area QCC serves, if this booklet-certificate covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area QCC serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area QCC serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them, that are specifically excluded from, or in excess of the limits of, coverage provided by this booklet-certificate.

**B. Non-Participating Healthcare Providers Outside the QCC Service Area**

Please refer to the Covered Expense definition in the Defined Terms section of the booklet-certificate.
VII. The Managed Care section is revised as follows:

1. The second paragraph of item D. Precertification Review subsection is replaced by the following:

   While the majority of services requiring Precertification review are reviewed for Medical Necessity of the requested procedure setting (e.g., Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing provider. Precertification review is not required for Emergency services.

2. The second paragraph of the Inpatient Pre-Admission Review section is replaced by the following:

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

3. The second paragraph of the Emergency Admission Review section is replaced by the following:

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

4. Item E. Other Precertification Requirements is replaced by the following:

E. OTHER PRECERTIFICATION REQUIREMENTS

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

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

The Covered Person is responsible to have the Provider performing the service contact the Carrier to initiate Precertification. The Carrier will verify the results of the Precertification with the Covered Person and the Provider.

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

**Precertification Penalty:**

You will be subject to a 20% reduction in benefits if precertification is not obtained.

In addition to the Precertification requirements listed above, the Covered Person should contact the Carrier for certain categories of treatment (listed below) so that the Covered Person will know prior to receiving treatment whether it is a Covered Service. Those categories of treatment (in any setting) include:

1. Any surgical procedure that may be considered potentially cosmetic;
2. Any procedure, treatment, drug or device that represents “emerging technology”, and
3. Services that might be considered Experimental/Investigative.

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

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

5. The Services Requiring Precertification subsection is deleted.

Effective January 1, 2012:

The second paragraph of the Emergency Care Services subsection of the Description of Benefits is replaced by the following:

Emergency Care services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are covered by the Carrier. Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency.

All other terms of your Booklet/Certificate shall remain in effect.

John R. Janney  
Sr. Vice President  
Marketing Services
Programs
For Your Well Being
SECTION OVERVIEW

Wellness Guidelines

A message about your health ................................................................. 5.1
Recommendations birth – 20 years ..................................................... 5.2
Recommendations 21 years and older ............................................... 5.3

General Health Tools for Everyone

Resources ............................................................................................. 5.5
Tips to stay healthy and safe ................................................................. 5.6
Topics to discuss with your health care provider.............................. 5.6

Healthy Lifestyles™

Financial rewards .................................................................................. 5.9
Decision support tools .......................................................................... 5.11
Personal health coach ............................................................................ 5.13
Wellness guidelines for all ages

Live healthy, stay safe
Take a few minutes to review for you and your family

We're here for you every step of the way

Independence Blue Cross
Thank you for choosing Independence Blue Cross.

Your health and wellness are important. They’re why we provide you with these wellness guidelines to help you and your family stay healthy. The wellness guidelines are a summary of recommendations from the U.S. Preventive Services Task Force and other nationally recognized sources. These recommendations have also been reviewed by some of our network health care providers.

We encourage you to take the time to review these guidelines. Use them as a starting point for conversations with your and your child's health care providers. Your health care provider may recommend alternatives to the information outlined in these wellness guidelines based on your specific needs and the history of health or illness in your family. Please visit www.ibxpress.com for the most up-to-date wellness guidelines and for more resources on how to stay healthy.

We hope you will find the wellness guidelines both educational and useful in helping you and your family stay in the best of health.

Sincerely,

Richard L. Snyder, M.D.
Senior Vice President
Chief Medical Officer

This booklet is not a statement of benefits. Please refer to your health benefits, plan contract, member handbook, or benefits handbook for terms, limitations, or exclusions of your health benefits plan. Benefits may vary based on state requirements, product line (HMO, PPO, etc.), and/or health employer group. Please contact Customer Service at 1-800-ASK-BLUE with questions about which preventive care benefits apply to you. Individual member coverage should be verified with the plan.
# Recommendations

## Birth – 20 years

<table>
<thead>
<tr>
<th>History &amp; physical</th>
<th>Birth – 10 years</th>
<th>11 – 20 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First visit after birth:</strong> includes length, weight, head circumference, weight for length, developmental review, and psychosocial/behavioral assessment; newborn metabolic/hemoglobin screening if not done at birth; and other screenings if at risk (blood pressure, hearing, vision)</td>
<td></td>
<td>Annually, including height, weight, BMI, blood pressure, developmental review, psychosocial/behavioral assessment; vision at 12, 15, and 18 years; and other screenings if at risk (hearing, hemoglobin or hematocrit, tuberculosis)</td>
</tr>
<tr>
<td><strong>Well visits (until 3 years):</strong> by 1 month, then at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, including length/height, weight, head circumference until 24 months, weight for length until 18 months, then body mass index (BMI), developmental review, and psychosocial/behavioral assessment; developmental screening at 9, 18, and 30 months; hemocrit or hemoglobin screening at 12 months; autism screening at 18 and 24 months; and other screenings if at risk (blood pressure, hearing, lead, tuberculosis, vision)</td>
<td></td>
<td>Discuss tobacco, alcohol/drug use, and environmental/occupational risk factors</td>
</tr>
<tr>
<td><strong>Well visits (3 – 10 years):</strong> every year, including height, weight, BMI, blood pressure, developmental review, psychosocial/behavioral assessment; vision at 3 years; hearing and vision at 4, 5, 6, 8, and 10 years; and other screenings if at risk (hemoglobin or hematocrit, lead, tuberculosis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annually, including height, weight, BMI, blood pressure, developmental review, psychosocial/behavioral assessment; vision at 12, 15, and 18 years; and other screenings if at risk (hearing, hemoglobin or hematocrit, tuberculosis)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Check with your health care provider that all immunizations are up to date. For immunization schedules visit <a href="http://www.cdc.gov/vaccines/recs/schedules">www.cdc.gov/vaccines/recs/schedules</a> †</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diabetes screening</th>
<th>Every 3 years starting at age 10 or start of puberty for overweight youths who also have 2 additional risk factors including family history of diabetes, abnormal cholesterol test, high blood pressure, polycystic ovarian syndrome in females, or being a member of a high-risk ethnic population (African American, Asian American, Latino, Native American, Pacific Islander)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Cholesterol test (fasting) (total cholesterol, low-density lipoprotein [LDL], high-density lipoprotein [HDL], and triglycerides)</th>
<th>If at risk, consider screening starting at 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider screening if at risk or starting at age 20</td>
<td></td>
</tr>
<tr>
<td>Risk factors include family history of early coronary heart disease and parental history of high cholesterol</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pap test (females)</th>
<th>Not nationally recommended for this age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start 3 years after onset of vaginal intercourse or by age 21; then every 1 – 2 years depending on type of test</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexually transmitted disease screening</th>
<th>Not nationally recommended for this age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss prevention and screening as appropriate; sexually active females ages 24 and younger should be screened for chlamydia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression/suicide risk</th>
<th>Discuss needs and assessment with your child’s health care provider</th>
</tr>
</thead>
</table>

---

*Your health care provider may suggest alternative tests/screenings to those listed. Wellness guidelines are constantly changing, and these guidelines were current at the time of publishing. Please discuss your individual needs and the recommended wellness guidelines with your health care provider. For coverage information and questions, please contact Customer Service at 1-800-ASK-BLUE. Please refer to your health benefits contract for complete details of terms, limitations, and exclusions of your health care coverage.

†Pregnant members, please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® program and to find out how to get more information on screenings specific to pregnancy.

‡If you do not have Internet access, call 1-800-ASK-BLUE to request a copy of the immunization schedules.
## Recommendations**†

### 21 years and older

<table>
<thead>
<tr>
<th></th>
<th>21 – 39 years</th>
<th>40 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History &amp; physical</strong></td>
<td>At age 21, then every 2 years</td>
<td>Every 1 – 2 years to age 65, then annually</td>
</tr>
<tr>
<td></td>
<td>Includes height, weight, BMI, blood pressure</td>
<td>Includes height, weight, BMI, blood pressure</td>
</tr>
<tr>
<td></td>
<td>Discuss tobacco, alcohol/drug use, and environmental/occupational risk factors</td>
<td>Discuss tobacco, alcohol/drug use, environmental/occupational risk factors, and cognitive function; discuss need for hearing screening/ vision screening with your health care provider</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Check with your health care provider that all immunizations are up to date.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For immunization schedules visit <a href="http://www.cdc.gov/vaccines/recs/schedules">www.cdc.gov/vaccines/recs/schedules</a> ‡</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>If at risk or as recommended by your health care provider</td>
<td>Every 3 years beginning at age 45, if at risk, or as recommended by your health care provider</td>
</tr>
<tr>
<td></td>
<td>Adults at risk are overweight or obese and have additional risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>including physical inactivity, having a first-degree relative with diabetes,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>abnormal cholesterol test, high blood pressure, women who had diabetes during pregnancy or have polycystic ovarian syndrome, or being a member of a high-risk ethnic population (African American, Asian American, Latino, Native American, Pacific Islander)</td>
<td></td>
</tr>
<tr>
<td><strong>Cholesterol test (fasting)</strong></td>
<td>Every 5 years starting at age 20</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>(total cholesterol, low-density lipoprotein [LDL], high-density lipoprotein [HDL], and triglycerides)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>Not nationally recommended for this age group</td>
<td>Starting at age 50, follow one of the following testing schedules:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• every 10 years: colonoscopy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• or every 5 years: flexible sigmoidoscopy§</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• or every 5 years: computed tomography (CT) colonoscopy§</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(virtual colonoscopy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• or talk with your health care provider about an annual take-home multiple-sample stool test§ as another screening option (fecal immunochemical test [FIT] or high-sensitivity fecal occult blood test [FOBT])</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• or talk with your health care provider about stool DNA testing§ (ColoSure™) as another screening option. The screening interval for this test is uncertain and should be discussed with your health care provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss screening before age 50 with your health care provider if you are African American, you have a family history of colorectal cancer or polyps, or you have a history of inflammatory bowel disease. If you are approaching or older than age 75, discuss the age to stop routine screening with your health care provider. § Colonoscopy should be done if results are positive. ¥ Stool tests are less likely to find polyps compared to the other tests listed above; therefore, colonoscopy, flexible sigmoidoscopy, or computed tomography (CT) colonoscopy are preferred testing methods for colon cancer screening.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>§ Colonoscopy should be done if results are positive.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¥ Stool tests are less likely to find polyps compared to the other tests listed above; therefore, colonoscopy, flexible sigmoidoscopy, or computed tomography (CT) colonoscopy are preferred testing methods for colon cancer screening.</td>
</tr>
</tbody>
</table>

*Your health care provider may suggest alternative tests/screenings to those listed. Wellness guidelines are constantly changing, and these guidelines were current at the time of publishing. Please discuss your individual needs and the recommended wellness guidelines with your health care provider. For coverage information and questions, please contact Customer Service at 1-800-ASK-BLUE. Please refer to your health benefits contract for complete details of terms, limitations, and exclusions of your health care coverage.

†Pregnant members, please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® program and to find out how to get more information on screenings specific to pregnancy.

‡If you do not have Internet access, call 1-800-ASK-BLUE to request a copy of the immunization schedules.
### Recommendations**†

#### 21 years and older

<table>
<thead>
<tr>
<th>Test</th>
<th>21 – 39 years</th>
<th>40 and older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prostate screening (males)</strong></td>
<td>Not nationally recommended for this age group</td>
<td>Starting at age 50, discuss screening options with your health care provider; if at high risk (African American men and men with a family history of a first-degree relative with prostate cancer diagnosed before age 65), discuss at age 45; if more than one first-degree relative was diagnosed with prostate cancer at an early age, screening can begin at age 40. If you are approaching or are older than age 75, discuss the age to stop routine screening with your health care provider.</td>
</tr>
<tr>
<td><strong>Abdominal aortic aneurysm screening (males)</strong></td>
<td>Not nationally recommended for this age group</td>
<td>Once for men aged 65 – 75 who have ever smoked.</td>
</tr>
<tr>
<td><strong>Mammography (females)</strong></td>
<td>Not nationally recommended for this age group</td>
<td>Every 1 – 2 years</td>
</tr>
</tbody>
</table>
| **Pap test (females)**                    | Start 3 years after onset of vaginal intercourse or by age 21; then every 1 – 2 years depending on the type of test; after age 30, testing may be decreased to every 2 – 3 years (after 3 normal Pap tests in a row); an acceptable alternative may be the human papillomavirus (HPV) DNA test plus cervical cytology (standard or liquid-based Pap test) every 3 years. It may be appropriate for women who have had a total hysterectomy to stop cervical cancer screening. | Every 1 – 2 years, depending on type of test, then every 2 – 3 years after 3 normal Pap tests in a row; an acceptable alternative may be the human papillomavirus (HPV) DNA test plus cervical cytology (standard or liquid-based Pap test) every 3 years. It may be appropriate for women who have had a total hysterectomy to stop cervical cancer screening.  
*Note:* After age 70, with 3 normal Pap tests in a row and no abnormal tests in last 10 years, or if total hysterectomy was done, discontinuation of screening may be appropriate. |
| **Osteoporosis screening (females)**      | Not nationally recommended for this age group                               | Begin screening at age 60 if at increased risk (including weight < 154 pounds) for fractures; otherwise, start screening at age 65. |
| **Sexually transmitted disease screening**| Discuss prevention and screening with your health care provider; sexually active females ages 24 and younger and females older than age 24 at increased risk should be screened for chlamydia. |                                                                                   |
| **Depression/suicide risk**               | Discuss needs and assessment with your health care provider                |                                                                                   |

*Your health care provider may suggest alternative tests/screenings to those listed. Wellness guidelines are constantly changing, and these guidelines were current at the time of publishing. Please discuss your individual needs and the recommended wellness guidelines with your health care provider. For coverage information and questions, please contact Customer Service at 1-800-ASK-BLUE. Please refer to your health benefits contract for complete details of terms, limitations, and exclusions of your health care coverage.  
†Pregnant members, please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® program and to find out how to get more information on screenings specific to pregnancy.
Information in this booklet is based on the following sources:

- Advisory Committee on Immunization Practices, www.cdc.gov/vaccines/recs/schedules
- American Cancer Society, www.cancer.org
- American Heart Association, www.americanheart.org
- Centers for Disease Control and Prevention, Body Mass Index (BMI), www.cdc.gov/nccdphp/dnpa/bmi
- Specialty Consultant Review

Additional resources:

- Planning for Pregnancy, Centers for Disease Control and Prevention, Preconception Care Questions and Answers, www.cdc.gov/ncbddd/preconception/QandA.htm
- For pregnant members:
  Please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® program and to find out how to get more information on screenings specific to pregnancy. As soon as you think you are pregnant, schedule your first prenatal appointment. An initial exam should be done within three months of pregnancy with follow-up examinations as recommended by your health care provider.

Please be advised that once you go to a website not maintained by Independence Blue Cross (IBC), you will be at websites maintained by organizations that IBC does not control. The websites are to be used as a reference for informational purposes only and are not intended to replace the care and advice of medical professionals. IBC is not responsible for the content or for validating the content nor is it responsible for any changes or updates made. Once you link to a website not maintained by IBC, you are subject to the terms and conditions of that website, including, but not limited to, its privacy policy.
Wellness guidelines

Tips to stay healthy and safe:

• Adhere to a healthy diet and maintain a healthy weight.
• Practice regular physical activity as recommended by your health care provider.
• Follow good oral hygiene, including tooth brushing with fluoride toothpaste, flossing daily, and regular dentist visits.
• Avoid illegal drug use, tobacco use, and excessive alcohol use.
• Adopt sensible sun protection/safety practices.
• Use appropriate protective/safety practices and gear when engaged in recreational activities.
• Practice regular use of seat belts, car seats, and air bags as appropriate.
• Store firearms, matches, medications, and toxic chemicals safely.
• Keep the number for poison control handy (1-800-222-1222).
• Properly install, test, and maintain smoke/carbon monoxide detectors.
• Use flame-retardant sleepwear for all children; maintain proper sleep environment/position for infants.
• Evaluate your home for risk of falls and other injuries, especially if there are young children and/or older individuals in the home.
• Keep your hot water heater at a temperature less than 120 degrees.

*Your health care provider may suggest alternative tests/screenings to those listed. Wellness guidelines are constantly changing, and these guidelines were current at the time of publishing. Please discuss your individual needs and the recommended wellness guidelines with your health care provider. For coverage information and questions, please contact Customer Service at 1-800-ASK-BLUE. Please refer to your health benefits contract for complete details of terms, limitations, and exclusions of your health care coverage.

†Pregnant members, please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® program and to find out how to get more information on screenings specific to pregnancy.

‡If you do not have Internet access, call 1-800-ASK-BLUE to request a copy of the immunization schedules.

Topics to discuss with your health care provider

Make the most of each visit with your or your child’s health care provider. Bring a list of topics to discuss. We suggest the following:

☐ Discuss any individual or family health history that may affect your current health status.
☐ Review any screening results such as blood pressure, height, weight, body mass index (BMI), and cholesterol.
☐ Review taking medication safely and correctly; routinely review usage/dosage of medications, including over-the-counter and oral supplements such as herbas, vitamins, and minerals.
☐ Check that all age-appropriate immunizations are up to date, including flu, pneumococcal, and tetanus vaccinations (see specific immunization schedules: www.cdc.gov/vaccines/recs/schedules†).
☐ Discuss feelings of sadness and/or depression.
☐ Review your risk of violence, signs of abuse, and risk of neglect.
☐ Review sleeping concerns and ways to reduce stress.
☐ Review dental health for infants and children including how to prevent baby bottle tooth decay and the need for fluoride supplements.
☐ If sexually active, discuss birth control options, family planning, and ways to prevent sexually transmitted diseases.
☐ Review if you are at increased risk for heart disease and if aspirin is recommended.
☐ Review need for diabetes, vision, glaucoma, and bone density screenings.
☐ Females: Ask about the benefits and limitations of breast self-exam.
☐ Females: Ask about managing menopausal signs and symptoms and available treatment options.
For more information on our Healthy Lifestyles programs:

Please visit our website at www.ibxpress.com or call the Health Resource Center at 1-800-ASK-BLUE or 1-215-241-3367, TTY/TDD: 1-888-857-4816, Monday through Friday, 8 a.m. to 6 p.m. ET.

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association. © The Blue Cross and/or Blue Shield words and symbols and Baby BluePrints are registered marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.
Take advantage of:

- financial rewards
- decision support tools
- personal health coach

Healthy Lifestyles™ — programs for every stage of your health

We’re here for you every step of the way.
Enjoy financial rewards and incentives

Our unique Healthy Lifestyles programs offer cash rewards, discounts, information, and reminders designed to help you and your family lead healthier lives. These programs are easy to join and include:

**Cash rewards**

- up to $150 reimbursement on fitness center fees;*
- up to $200 reimbursement for successfully completing a smoking cessation program;*
- up to $200 back for the cost of a weight-management program;*

*These programs require enrollment.

- up to $25 back for each bike helmet you purchase for yourself or a covered dependent;
- up to $25 back for successfully completing an authorized CPR or first-aid course;
- up to $50 back for a parenting class, $50 back on the purchase of a breast pump, and $100 back for a lactation consultant.

Visit [ibx.com](http://ibx.com), or call **1-800-ASK-BLUE** (1-800-275-2583).
Discounts

- valuable discounts on massage therapy, acupuncture, vitamins and supplements, and yoga books and DVDs;
- exclusive discounts on CorCell®, a program that preserves your child’s umbilical cord blood — a vital resource that can help combat a variety of life-threatening diseases.

Information

- Personal Health Profile provides you with a detailed report on your possible health risks;
- stress management and better sleep informational kit;
- Baby BluePrints® maternity program provides a risk assessment, maternity nurse support, and information on what to expect during your pregnancy;
- adoption education services provide essential information and resources, including books and specialty items.

Reminders

- educational reminders for members to schedule important preventive health screenings, such as mammograms, Pap tests, and colorectal screenings;
- special reminders and resource mailings to keep the whole family up to date on immunizations and vaccinations.

*Independence Blue Cross has a minority ownership interest in CorCell, Inc.’s parent company. CorCell is an independent company offering a discount on cord blood preservation services to Independence Blue Cross (IBC) members. CorCell does not offer Blue Cross and/or Blue Shield products or services. CorCell is solely responsible for its products and services.
Make informed decisions

When it comes to making decisions regarding your health care, you aren’t alone. We provide a comprehensive support system to help you with significant treatment decisions or everyday health concerns.

Access to a Health Coach 24/7

Your own personal Health Coach is available anytime to answer your questions and to help you make knowledgeable, confident decisions regarding your health care. Your Health Coach can provide:

- information on everyday health concerns, such as headaches and joint pain;
- help if you are facing a significant medical decision, such as treatment options for back pain, breast or prostate cancer, or surgery;
- personalized calls about your chronic condition or other health concerns;
- information to help you know the right questions to ask your doctor.

Blue Distinction Centers*

The Blue Distinction Centers for specialty care are quality providers of weight loss (bariatric) surgery, cardiac care, and transplant services nationwide. Designated centers have extensive experience, meet rigorous quality standards, and consistently demonstrate positive results.

Visit ibx.com, or call 1-800-ASK-BLUE (1-800-275-2583).
Online tools through ibxpress.com

Our convenient and secure website gives you access to pricing tools and health information, including:

- **Provider finder.** Find quality ratings, patient safety data, and hospital cost information for participating doctors and hospitals.

- **Treatment cost estimator.** Estimate the cost of services related to a specific condition or procedure, including doctor’s visits, medications, and tests, before you receive care.

- **Health plan selector.** Evaluate the right plan for your health care needs based on your health profile and the average cost of each service.

- **Prescription drug tools.** Compare costs of prescription drugs, locate participating pharmacies, request mail order prescription refills, and check drug-to-drug interactions.

Other tools and resources

Our full range of decision support tools also includes:

- **Health encyclopedia** — access to a well-organized encyclopedia of health topics — on the Web or through the mail;

- **Audio library** — more than 470 health care topics from arthritis and anxiety, to pneumonia and immunizations;

- **Decision support videos** — a wide variety of free informational videos/DVDs on topics such as weight loss surgery, coping with depression, chronic lower back pain, and breast cancer, that help you decide about important treatment options.

*Available only with Independence Blue Cross Prescription Drug coverage.
Get personal support

From developing a care plan for treating your chronic disease to teaching you how to best control asthma, our Connections™ Health Management Programs offer support to help you make the choices that are right for you.

Our Health Coaches will work side by side with you to help you understand your condition, provide coping strategies, and monitor your progress.

With Connections, you’ll:

- gain a better understanding of your health condition and the treatment options available to you;
- learn to communicate more effectively with your doctor regarding your health concerns;
- learn to recognize the early warning signs that your condition is getting worse and take steps to avoid long-term complications;
- receive personalized calls and reminder letters to keep you motivated and up to date on your care;
- benefit from a comprehensive support network that teaches you and your family how to better manage your condition with your doctors.

Visit ibx.com, or call 1-800-ASK-BLUE (1-800-275-2583).
For questions and eligibility requirements, visit us at [www.ibx.com](http://www.ibx.com), or call the Health Resource Center at 1-800-ASK-BLUE or 215-241-3367, TDD 1-888-857-4816, Monday through Friday, 8 a.m. to 6 p.m.
INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

“Protected health information” or “PHI” is information about you, including information about where you live, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:
- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

1 If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group’s privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

2 For purposes of this Notice, “Independence Blue Cross” refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.
EFFECTIVE APRIL 14, 2003

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members’ protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or “HIPAA”) Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

This Notice takes effect on April 14, 2003, and will remain in effect until we replace or modify it.

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.
Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other IBC affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available IBC health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: We may use your PHI to make a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose “summary health information” to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. “Summary health information” is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor’s group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.
Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct audits and investigations of the health care system, to determine eligibility for government programs, to determine compliance with government program standards, and for certain civil rights enforcement actions.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
• as necessary to report a crime on our premises;
• to report a death that we believe may be the result of criminal conduct; or
• in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Workers’ Compensation: As part of your workers’ compensation claim, we may have to disclose your PHI to a worker’s compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a “designated record set.” Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called “Your Privacy Rights Concerning Your Protected Health Information.”

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed IBC Personal Representative Designation Form or documentation that supports the person’s qualification according to state law (such as a power of attorney or guardianship). To request the IBC Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.
To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child’s PHI to you. However, we may be required to deny a parent’s access to a minor’s PHI according to applicable state law.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoke your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved IBC Authorization Form. To request the IBC Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at ww.ibx.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)
You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved IBC form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy
psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

**Right to Amend Your PHI:** You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross’s vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

**Right to an Accounting of Certain Disclosures:** You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an “Accounting”). Any accounting of disclosures will not include those we made:
- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

**Right to Request Restrictions:** You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

**Right to Request Confidential Communications:** You have the right to request, in writing, that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all
or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber’s right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

**Right to a Paper Copy of This Notice:** You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

**Your Right to File a Privacy Complaint**
If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross’s privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your Member Identification Card, or you may contact the Privacy Office as follows:

Independence Blue Cross  
Privacy Office  
P.O. Box 41762  
Philadelphia, PA 19101 - 1762  
Fax: (215) 241-4023 or (888) 678-7006 (toll free)  
E-mail: Privacy@ibx.com  
Phone: (215) 241-4735 or (888) 678-7005 (toll free)
**Biotech/Specialty Injectables List**  (list subject to change)

<table>
<thead>
<tr>
<th>Multiple Sclerosis Agents/Interferon Beta Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Avonex</td>
</tr>
<tr>
<td>- Copaxone</td>
</tr>
<tr>
<td>- Betaseron</td>
</tr>
<tr>
<td>- Rebif</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Botulinum Toxin Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Botox</td>
</tr>
<tr>
<td>- Myobloc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Migraine Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Imitrex Injection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunological Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Amevive</td>
</tr>
<tr>
<td>- Enbrel</td>
</tr>
<tr>
<td>- Kineret</td>
</tr>
<tr>
<td>- Humira</td>
</tr>
<tr>
<td>- Raptiva</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hepatitis/Interferon Alfa Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Intron A</td>
</tr>
<tr>
<td>- Peg Intron</td>
</tr>
<tr>
<td>- Rebetron</td>
</tr>
<tr>
<td>- Pegasys</td>
</tr>
<tr>
<td>- Roferon-A</td>
</tr>
<tr>
<td>- Actimmune</td>
</tr>
<tr>
<td>- Alferon</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anticoagulant/Low Molecular Weight Heparin Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lovenox</td>
</tr>
<tr>
<td>- Fragmin</td>
</tr>
<tr>
<td>- Arixtra</td>
</tr>
<tr>
<td>- Innohep</td>
</tr>
<tr>
<td>- Orgaran</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Endocrine/Metabolic Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lupron</td>
</tr>
<tr>
<td>- Zoladex</td>
</tr>
<tr>
<td>- Trelstar</td>
</tr>
<tr>
<td>- Sandostatin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hyaluronate Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Hyalgan</td>
</tr>
<tr>
<td>- Orthovisc¹</td>
</tr>
<tr>
<td>- Synvisc</td>
</tr>
<tr>
<td>- Supartz</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Growth Hormones</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Nutropin</td>
</tr>
<tr>
<td>- Nutropin AQ</td>
</tr>
<tr>
<td>- Humatrope</td>
</tr>
<tr>
<td>- Saizen</td>
</tr>
<tr>
<td>- Serostim</td>
</tr>
<tr>
<td>- Protropin</td>
</tr>
<tr>
<td>- Genotropin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hematopoietic Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Epogen</td>
</tr>
<tr>
<td>- Procrit</td>
</tr>
<tr>
<td>- Neupogen</td>
</tr>
<tr>
<td>- Aranesp</td>
</tr>
<tr>
<td>- Neulasta</td>
</tr>
<tr>
<td>- Leukine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory Agents</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Xolair</td>
</tr>
<tr>
<td>- Synagis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Apokyn</td>
</tr>
<tr>
<td>- Fuzeon</td>
</tr>
<tr>
<td>- Forteo</td>
</tr>
<tr>
<td>- Somavert</td>
</tr>
<tr>
<td>- Thyrogen</td>
</tr>
</tbody>
</table>

¹ Added to the Biotech/Specialty Injectables List effective 8/1/05.
Injectable Drug Coverage for

*Flex Series Medical Plans*

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.
Flex Series Injectable Drug Coverage

How to Obtain Injectable Drug Coverage
As a member of Independence Blue Cross (IBC), your Flex Series medical plan provides coverage for most injectable medications. Injectable drugs are those medications that cannot be taken orally and must be injected into the body.

Determining the Type of Injectable Medication
Under your Flex Series benefit program, injectable medications fall into two categories—Standard injectables and Biotech/Specialty injectables. Standard injectables (e.g. steroids or antibiotics) are typically administered by a physician. Biotech/Specialty injectables (e.g. growth hormones) can be either self-administered or administered by your physician. If you are not sure if your injectable drug is a Biotech/Specialty injectable, simply consult the detailed list on the back of this brochure.

How To Obtain Biotech/Specialty Injectable Drugs
To receive your highest level of coverage, order all your Biotech/Specialty injectables through IBC, regardless of whether you are using an in-network or out-of-network provider. Your physician may call (888) 671-5280, option 4, to initiate your order. IBC will facilitate the shipping of your Biotech/Specialty injectable medication to your physician’s office or to you directly for self-administration. If your physician has a supply of the Biotech/Specialty injectable medication in his or her office, IBC must be notified prior to the administration of the Biotech/Specialty injectable.

All Biotech/Specialty injectable medications require precertification from IBC before your prescription can be filled.

Maximize your coverage for Biotech/Specialty Injectable Drugs
When ordered through IBC, Biotech/Specialty injectables will require a flat copayment, which is listed in your benefit materials. If you are prescribed a Biotech/Specialty injectable medication, your doctor may choose to write the prescription for a certain number of days (i.e. 30-day supply), or for a course of therapy. You will be required to pay your copayment for up to a 30-day supply or the course of therapy. This copayment will apply when the prescription is ordered and will be collected by IBC’s injectable vendor prior to shipment.

Contact us at (215) 241-2273 (if calling within Philadelphia) or (800) 227-3114 (outside of Philadelphia) for more information about injectable medication coverage.
**Frequently Asked Questions About Injectables**

**Q: What are injectables?**
A: Injectables are medications that cannot be taken orally. They are in a liquid form that must be injected into the body through a vein, the skin or a muscle.

**Q: Are injectables covered under my medical plan?**
A: Your Flex Series medical plan provides coverage for most Standard and Biotech/Specialty injectables.

**Q: What is a Standard injectable?**
A: Standard injectables are commonly given in the physician’s office to treat acute or short-term episodes of illness. Examples of standard injectables are steroids, injectable vitamins and antibiotics.

**Q: What is a Biotech/Specialty injectable?**
A: Biotech/Specialty injectables are medications that represent new and emerging technology, and that are typically used to treat chronic illnesses. These injectables can be either self-administered or administered in a physician’s office. Growth hormones are examples of Biotech/Specialty injectables.

**Q: How are injectables covered through my Flex Series plan?**
A: Standard injectables must be administered by your physician in his or her office. Biotech/Specialty injectables must be ordered by your physician through Independence Blue Cross (IBC) and may be administered in his or her office or may be self-administered. All Biotech/Specialty injectables require precertification through IBC. Copayments are applicable to Biotech/Specialty Injectables. Check your benefit materials for details.

**Q: How are copayments for Biotech/Specialty injectables applied?**
A: Your copayment will apply for up to a 30-day supply of medication administered on a regularly scheduled basis. If your medication is administered on an intermittent basis, the copayment applies to each course/series of injections, not to exceed a 30-day supply.

**Q: Can I receive a supply greater than 30 days or one course/series of Biotech/Specialty injections?**
A: Yes, for chronic illnesses, your physician may arrange for a 90-day supply or three courses/series of injectables to be dispensed. If you receive a 90-day supply or three courses/series of injections of the prescribed injectable, you will be responsible for three copayments.

**Q: How will my physician obtain a Biotech/Specialty injectable?**
A: Independence Blue Cross will facilitate shipment of Biotech/Specialty injectables covered under your medical plan to your physician’s office. If the injectable is self-administered, IBC will arrange for the injectable to be shipped to you directly. All in-network and out-of-network physicians must contact IBC directly to arrange shipment of eligible injectables.

**Q: What if my physician directs me to a pharmacy for an injectable?**
A: Your physician should be reminded that injectables that are usually administered by a physician are not covered under your Flex Series medical plan when purchased at a retail pharmacy. Injectables on the Biotech/Specialty list must be obtained through IBC. Further questions from your physician regarding the process for ordering injectables on the Biotech/Specialty list should be directed to IBC at (888) 671-5280, option 4.
REPLACEMENT CONTACT LENSES BY MAIL

1-800-LENS123™
www.lens123.com

The Fastest, Easiest and Most Convenient Way To Buy Replacement Contact Lenses