HMO GROUP MASTER CONTRACT

issued by

Keystone Health Plan East, Inc. ("Keystone" or "the HMO")*

* independent corporation operating under a license
from Blue Cross and Blue Shield Association

A Pennsylvania corporation
Located at:
1901 Market Street
P.O. Box 7516
Philadelphia, PA 19101-7516

Description of Coverage:

This HMO Group Master Contract sets forth a comprehensive program of inpatient and outpatient health care benefits. In most cases, Members must obtain a Referral for any Covered Service, and benefits are provided only for services performed by a Participating Provider. Preapproval by Keystone Health Plan East, Inc. is required for any service requiring a Referral to a Provider who is not a Participating Provider. Certain benefits are subject to cost-sharing provisions such as Copayments.

The benefits in this Contract are provided through a health maintenance organization that utilizes a provider network through which the Member must access Covered Services, except in emergency situations. This Contract utilizes extensive Pre-authorization and Utilization Management procedures that must be followed to maximize benefits and avoid penalties.

Group Name: **CONTRACT HOLDER NAME**

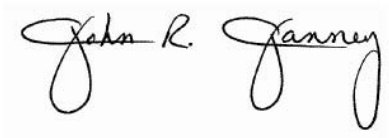
Group Contract Number(s): **CONTRACT NUMBER(S)**

In consideration of the Group Application and the payment of premiums to be paid to Keystone Health Plan East, Inc. ("Keystone" or "the HMO") by the Group, and subject to all terms of this Group Master Contract ("Contract"), the HMO hereby agrees to provide benefits for each eligible Member of the Group enrolled under **CONTRACT NUMBER(S)** the benefits as described in the Member Handbook and Riders listed in the **Section BD - Schedule of Benefit Documents** in accordance with the terms, conditions, limitations, and exclusions of this Contract.

All of the provisions of the Member Handbook and Riders attached to, and made a part of the Contract, apply to the Contract as if fully set forth in the Contract.

The Group may accept this Contract by making required payments to Keystone Health Plan East, Inc. Such acceptance renders all terms and provisions hereof binding on Keystone Health Plan East, Inc. and the Group. Keystone Health Plan East, Inc. accepts the Application of the Group at its home office in Philadelphia, Pennsylvania, which is the State of Issue.

The signature below is considered evidence of Keystone Health Plan East, Inc.'s acceptance of the Contract Holder's Group Application on the terms hereof and constitutes execution of the Group Master Contract(s) attached hereto on behalf of Keystone Health Plan East, Inc.



John R. Janney
SVP Marketing Services

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SECTION DE - DEFINITIONS

AMENDMENT – a modification to this Contract which changes the original terms of this Contract. The changes contained in the amendment can take the form of one of the following:

A. A statutory amendment which reflects a change in this Contract that has been automatically made to satisfy a requirement(s) of any state law, federal law or regulation that would apply to this Contract as provided in **Section GP - General Provisions**, Compliance with Law provision;

B. A managed health care amendment which reflects a change in the Group's benefits where:

   1. The benefits are for services and supplies provided through the HMO's Providers; and

   2. The change applies to all group contracts that include these benefits.

   When this Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the managed health care amendment;

C. A universal amendment which reflects a change in the HMO's administration of its group benefits and is intended to apply to all group contracts which are affected by the change.

   When the Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the universal endorsement, unless the Group has rejected the Amendment in writing prior to its effective date; or

D. Any combination of the amendments shown above.

APPLICANT – a subscriber who applies for coverage under this Contract which the HMO has entered into with the Group.

APPLICATION – the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the HMO. Such request applies whether it was made under a prior carrier contract which is superseded by this Contract, or under this Contract. Also, referred to as the Group Application.

CONTRACT DATE – 12:01 a.m. on the date specified on the Application page of this Contract, on which coverage under this Contract commences for the Group.

COVERED SERVICE – as defined in the Member Handbook.

EFFECTIVE DATE OF COVERAGE – the date coverage begins for a Member under this Contract. All coverage begins at 12:01 a.m. on the date reflected on the records of the HMO.

EMPLOYEE – as defined in the Member Handbook.

ENROLLMENT/CHANGE FORM – the properly completed written request for enrollment in or change to the HMO membership submitted in a format provided by the HMO, together with any amendments or modifications thereof.

GROUP (CONTRACT HOLDER) – as defined in the Member Handbook.

GROUP MASTER CONTRACT (CONTRACT) – this agreement between the HMO and the Group, including the Enrollment Forms, Cover Sheet, Group Application, Acceptance Sheet, Schedules, Member Handbook, Riders and/or Amendments if any. Also referred to as the Group Contract.

KEYSTONE HEALTH PLAN EAST, INC. ("KEYSTONE" OR "THE HMO") – a health maintenance organization providing comprehensive health care to Members.

MEDICALLY NECESSARY – as defined in the Member Handbook.

MEMBER – as defined in the Member Handbook.

PARTICIPATING HOSPITAL – as defined in the Member Handbook.

PARTICIPATING PROVIDER – as defined in the Member Handbook.

REFERRED or **REFERRAL** – as defined in the Member Handbook.

RIDER – a document which describes the changes that are being made to the Member Handbook, whether by expanding, decreasing or defining benefits, or adding or excluding certain conditions from coverage.

SUBSCRIBER – as defined in the Member Handbook.

SECTION GP - GENERAL PROVISIONS

ASSIGNMENT

Except as set forth in this Contract, the Group is solely responsible for the performance of its obligations set forth in this Contract. The Group cannot assign, delegate, or transfer to any party the rights, duties, or obligations described in this Contract, any interest in this Contract, or any claim under this Contract without the prior express written consent of the HMO.

CLERICAL RECORDS OF MEMBER

A. The Group shall maintain accurate and timely records pertaining to Members and payments. The Group must also furnish the HMO with any data required by the HMO for coverage of Members under this Contract. In addition, the Group must provide written notification to the HMO within **thirty (30) days** of the effective date of any changes in a Member's coverage status under this Contract.

B. All notification by the Group to the HMO must be furnished on forms approved by the HMO. The notification must include all information required by the HMO to effect changes.

C. Clerical error, whether of the Group or the HMO, in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Determination of clerical error shall be at the sole discretion of the HMO.

D. If Contract benefits are approved by the HMO for Covered Services rendered to a Member before the HMO receives notice of the Member's termination under the Contract, the cost of such benefits will be the sole responsibility of the Member. The effective date of termination of a Member under the Contract shall not be more than **sixty (60) days** before the first day of the month in which the Group notified the HMO of the termination.

COMPLIANCE WITH LAW

If the provisions of the Contract do not conform to the requirements of any state or federal law or regulation that applies to the Contract, the Contract provisions are automatically changed to conform with the HMO's interpretation of the requirements of that law or regulation.

ELIGIBILITY REQUIREMENTS

The Group is responsible for maintaining eligibility of Members to receive benefits under the Contract and for timely notifying the HMO of such eligibility. The HMO will provide coverage, and terminate coverage, in reliance on the Group's timely notification of the eligibility of Members. If a Group fails to timely notify the HMO of the eligibility status of a particular Member, the HMO will provide and terminate coverage in accordance with any HMO administrative processes, such as verification of student dependents. The Group will be responsible for the payment of premiums for Members in accordance with such administrative processes.

ENTIRE CONTRACT CHANGES

A. The entire Contract consists of:

   1. The Member Handbook listed in the **Section BD - Schedule of Benefit Documents**, which is made a part of this Contract;

2. All modifications to such Member Handbook that is attached to, and made a part of, this Contract by a Rider to the Member Handbook;
3. Any Amendment made to this Contract;
4. Individual applications, if any, of the Members; and
5. The forms shown in the **Table of Contents (TOC)** as of the Effective Date of Coverage of this Contract between the Group and the HMO.

B. This Contract states the terms of payment and coverage under which the Group may secure health benefits for its Members. This Contract, along with **Section GA - Group Application**, any Amendments including Riders, the Enrollment/Change Form(s), and the appropriate payment, is the entire Contract between the Group and the HMO.

No change in this Contract will be effective until approved by an authorized HMO officer. Approval must be noted on, or attached to, this Contract. No agent or representative of the HMO, other than an HMO officer, may otherwise change this Contract or waive any of its provisions. All statements made by the Group or by an individual Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense of a claim under this Contract unless it is contained in a written Application.

C. The Group may not transfer enrollment to another type of Contract issued by the HMO until the expiration of a period of one year from the Contract Date of this Contract, and thereafter from year to year, except as otherwise approved by the HMO. All applications for changes in Contract type shall be submitted on the appropriate form supplied by the HMO and, upon acceptance by the HMO, shall become a part of this Contract.

D. The HMO may amend this Contract with respect to any matter, including required payments, by mailing a postage-prepaid notice of the amendment to the Group at its address of record with the HMO at least **thirty (30) days** before the effective date of the Amendment. The Group's concurrence with such Amendment shall be established by continuation of payment for coverage hereunder after the effective date of the Amendment.

GRACE PERIOD

This Contract has a grace period of **thirty (30) days**. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force unless, prior to the date payment was due, the Group gave timely written notice to the HMO that the Contract is to be cancelled.

If the Group does not make payment during the grace period, the Contract will be cancelled effective on the last day of the grace period and the HMO will have no liability for services which are incurred after the grace period. The HMO has the right to collect all outstanding premiums, including the premium for the grace period, from the Group.

IDENTIFICATION CARDS

Identification Cards issued by the HMO to Members pursuant to this Contract are for identification purposes only. Possession of an HMO ID Card confers no rights to Covered Services or other benefits under this Contract. If any Member permits another person to use the Member’s ID Card, the HMO may revoke that Member’s ID Card.

INTERPRETATION OF CONTRACT

The laws of the Commonwealth of Pennsylvania shall be applied to interpretations of this Contract. Where applicable, the interpretation of this Contract shall be guided by the direct-service nature of the HMO's operations as opposed to a fee-for-service indemnity basis.

LIMITATIONS OF THE HMO'S LIABILITY

The HMO shall not be liable for any claim or demand because of damages arising out of, or in any manner connected with, injuries suffered by the Member while receiving care from any HMO Participating Provider, or from any Provider to which the Member has been Referred by the Participating Provider or the HMO. Further, the HMO shall not be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

MEMBER HANDBOOKS

The HMO will distribute to Members, or will give to the Group to distribute to each Member, an individual handbook. The handbook will describe the main features of the Member's coverage. They include:

A. How to access primary, specialist and hospital care;

B. A summary of benefits and limitations;

C. Any protection and rights when the coverage ends; and

D. Member rights and responsibilities.

The HMO will notify Members of any changes to the Member Handbook by distributing Riders to the Member, or to the Group for distribution to Members.

MODIFICATION

By this Contract, the Group makes the HMO coverage available to Members who are eligible under the **Eligibility, Change and Termination Rules under the Plan** in the **GENERAL INFORMATION** section of the Member Handbook listed in the **Section BD - Schedule of Benefit Documents**. However, this Contract shall be subject to Amendment, modification, or termination in accordance with any provision hereof or by mutual agreement between the HMO and the Group without the consent or concurrence of the Members. By electing the HMO or accepting the HMO benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

NOTICE

Any notice required under this Contract must be in writing. Notice given to the Group will be sent to the Group's address stated in **Section GA - Group Application**. Notice given to the HMO will be sent to the HMO's address stated in **Section GA - Group Application**. Notice given to a Member will be given to the Member in care of the Group or sent to the Member's last address furnished to the HMO by the Group. The Group, the HMO, or a Member may, by written notice, indicate a new address for giving notice.

The Group shall inform Members of the conditions of his or her eligibility, including Effective Date of Coverage and termination. In addition, a Group benefits representative, designated as such by notice to the HMO, shall communicate to Members all matters related to them by the HMO that a reasonable person would attach importance in determining the action to be taken. This notification shall be completed within the next regular communication, but in no event shall it be later than **thirty (30) days** after receipt from the HMO.

NOTICE OF CLAIM AND PROOF OF LOSS

A. **Notice of Claim**

The HMO will not be liable for any claims under this Contract unless proper notice is furnished to the HMO that Covered Services 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 a Covered Service has been rendered to the Member. Notice given by or on behalf of the Member to the HMO that includes satisfactory information identifying the Member who received the Covered Service 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.

B. **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 a Covered Service 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. However, 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 a Covered Service is incurred.

C. **Claim Forms**

If a Member, or his or her personal representative if Member is deceased, is required to submit a proof of loss for Benefits under this Contract, it must be submitted to the HMO on the appropriate claim form. The HMO will furnish proof of loss claim forms to the Member within **fifteen (15) days** following the date notice of claim is received. 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 regarding time frames for submission of an itemized bill for the Covered Service as described below. An itemized bill may be submitted to the HMO at the address appearing on the Member's ID Card. Itemized bills cannot be returned.

D. **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 Contract.

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.

E. **Timely Payment of Claims**

Claims payment for Benefits payable under this Contract will be processed immediately upon receipt of proper proof of loss.

POLICIES AND PROCEDURES

The HMO may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract, with which the Group and the Members shall comply.

PRESCRIPTION DRUG REBATE DISCLOSURE

The HMO anticipates that it will pass on a high percentage of the average expected prescription drug rebates it receives from its pharmacy benefits manager (PBM), which is an affiliate of the HMO, through reductions in future premium costs to the Group. Expected prescription drug rebates are based on historical drug rebates received by the HMO from its PBM, adjusted for known and anticipated changes in future rebate amounts. This includes, without limitation, adjustments for drugs for which the patent is expiring or changes in the HMO's PBM. While the HMO anticipates that it will be able to pass on a high percentage of the average expected prescription drug rebates, there may be instances when this amount could vary based on actual rebates that are either higher or lower than expected, such as the introduction of new drugs that may result in a higher rebate or other market conditions that are beyond the HMO's control. The Group acknowledges that any rebates beyond amounts that are passed on to the Group are for the sole benefit of the HMO and that neither the Group nor persons covered under the benefit program, nor anyone else, is entitled to receive any portion of such savings whether as part of any claims settlement or otherwise.

RELATIONSHIP OF PARTIES

A. The relationship that exists between the HMO and the HMO Participating Hospitals is that of an independent contractor. The HMO Participating Hospitals are not agents or employees of the HMO, nor is any employee of the HMO an employee or agent of the HMO Participating Hospitals. Each Hospital will maintain the hospital-patient relationship with the Member under the Contract and is solely responsible to the Member for Hospital Covered Services furnished to the Member.

B. The relationship between the HMO and the HMO Participating Providers, and between the HMO and other contracting Providers of health services, is an independent contractor relationship. The HMO Participating Providers are not agents or employees of the HMO, nor is any employee of the HMO an employee or agent of the HMO Participating Providers. Each Provider who is an HMO Participating Provider will maintain the provider-patient relationship with the Member under the Contract and is solely responsible to the Member for Covered Services furnished to the Member.

C. Neither the Group nor any Member under the Contract is the agent or representative of the HMO. Neither the Group nor any Member under the Contract will be liable for any acts or omissions:

1. Of the HMO, its agents or employees; or
2. Of any Hospital or other Provider with which the HMO, its agents or employees make arrangements for furnishing services and supplies to Members.

D. Members are free to choose their Primary Care Physician.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between the Group and Keystone, which is an independent corporation operating under a license from Blue Cross and Blue Shield Association, a national association of independent Blue Cross and Blue Shield Plans (the "Association"). 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 Blue Cross and Blue Shield words and symbols. Keystone, which is entering into this Contract, is not contracting as an agent of the Association. Only Keystone shall be liable to the Group for any of the Plan's obligations under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Keystone other than those obligations created under other provisions of this Contract.

RIGHT TO RECOVER PAYMENTS 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 Participating Provider or Member to whom such payment was made.

TERMINATION OF PARTICIPATING HOSPITAL OR PARTICIPATING SKILLED NURSING FACILITY CONTRACT

The contract between the HMO and a Participating Hospital or a Participating Skilled Nursing Facility may be terminated without notice to the Member provided that in the event of such termination, the Participating Hospital or the Participating Skilled Nursing Facility continue to render services and facilities to the Member that may be Inpatient at the time of such termination.

TERMINATION OF MEMBER COVERAGE BY THE GROUP

Coverage for the Member under this Group Contract will terminate on the date specified by the Group if the HMO receives from the Group notice of the termination of the Member's coverage within **sixty (60) days** of the date specified by the Group. If notification from the Group is *not* received by the HMO within **sixty (60) days** of the date specified by the Group, the effective date of termination of the Member's coverage under this Group Contract shall be **sixty (60) days** *prior* to the first day of the month in which the HMO received such notice of the Member's termination of coverage from the Group. However, this does not include any services covered under the **Inpatient Provision upon Termination of Coverage** in the **GENERAL INFORMATION** section of the Member Handbook attached to this Contract as listed in **Section BD - Schedule of Benefit Documents**.

If the Member is receiving Inpatient Care on the date coverage is terminated, the **Inpatient Provision upon Termination of Coverage** will apply as defined in the **Eligibility, Change and Termination Rules under the Plan** in the **GENERAL INFORMATION** section of the Member Handbook attached to this Contract as listed in **Section BD - Schedule of Benefit Documents**. Coverage for Dependents ends when the Member's coverage ends.

TERMINATION OF THE GROUP CONTRACT

A. The Group may terminate this Contract on any Contract anniversary by giving **thirty (30) days** written notice to the HMO. If the Group terminates this Contract pursuant to this paragraph, all rights to benefits hereunder terminate as of the effective date of termination.

B. This Contract shall terminate if the Group, in obtaining coverage hereunder, is guilty of fraud or material misrepresentation of fact. In such case, the HMO may, at its option, treat this Contract as cancelled. The Group will forfeit any charges paid to the extent of the liability incurred by the HMO.

C. This Contract will be terminated if the HMO does not receive from the Group the periodic payment due, subject to the Grace Period provisions listed above.

D. The HMO may also terminate the Group Contract if it withdraws a product or product option from the market.

E. The HMO reserves the right to terminate this Contract on any date if the Group fails to meet the HMO's eligibility and participation requirements. The HMO may advise at any time our intent to conduct an audit to determine the accuracy of the information supplied by the Group. The HMO will send written notice of such termination to the Group at least thirty (30) days before the effective termination date.

F. The HMO may, at its option, amend this Contract at least annually. If the Group does not agree to such change(s), the Group must notify the HMO in writing, within thirty (30) days, and the Group may terminate this Contract at the end of the then current Contract term.

G. Except as provided under the **Inpatient Provision upon Termination of Coverage** in the **GENERAL INFORMATION** section of the Member Handbook attached to this Contract as listed in **Section BD - Schedule of Benefit Documents**, the HMO shall not be liable for any services provided to any Member beyond the period for which the required payment shall have been received by the HMO. The HMO shall be entitled to indemnification by the Group for any expense paid by the HMO under such circumstances.

H. This Contract shall terminate at 12:01 a.m. on the date reflected on the records of the HMO.

TIME LIMIT ON CERTAIN DEFENSES

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

OUT-OF-AREA SERVICES

Keystone Health Plan East (“Keystone”) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever Members access healthcare services outside the geographic area Keystone serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this contract are described generally below.

Typically, Members, when accessing care outside the geographic area Keystone serves, 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, Members may obtain care from non-participating healthcare providers. Keystone 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 Keystone serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by the Member's Primary Care Physician ("PCP").

A. BlueCard® Program

Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, Keystone will remain responsible to you for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the healthcare provider's billed covered charges or the negotiated price made available to Keystone by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Keystone by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Keystone is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Keystone would then calculate Member liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

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

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

SECTION RA - RATING AND PAYMENT PROVISIONS

COVERAGE

Payment made to the HMO according to the terms of this Contract entitles all Members to coverage as defined in the Member Handbook and Riders attached to this Contract as listed in **Section BD - Schedule of Benefit Documents**, if applicable.

RATES AND PAYMENT

A. The Group, as remitting agent for or on behalf of the Members, agrees to pay the HMO on or before the first or fifteenth of each month the applicable rate. Such rate is filed with and approved by the Commonwealth of Pennsylvania and set forth in this Contract for all eligible persons who are enrolled with the HMO as Member's of this Group.

B. The HMO may change the premium rates at the end of the initial Contract period, and any time thereafter, by giving no less than **thirty (30) days** prior written notice to the Group.

   During the initial Contract period, no change in premium rates for any coverage provided by this Contract will be made unless there is a change:

   1. in any benefit or provision;
   2. in eligibility;
   3. resulting in the structure or composition of the Group varying by more than 10%; or
   4. made by Amendment or endorsement to this Contract.

   In addition, if a change in the Contract is required by statute or regulation which increases the HMO's risk under this Contract, the HMO may change the premium upon **thirty (30) days** written notice.

C. On or before the Effective Date of Coverage under this Contract, the Group shall furnish to the HMO, at a minimum, an initial report containing the names of eligible Members.

   Monthly thereafter, by such time as the HMO shall specify, the Group shall furnish to the HMO a report which lists the additions and deletions of Members.

   The HMO shall not be responsible for refunding payments made for ineligible Members omitted from the Group's monthly deletion report, unless the HMO is notified within **sixty (60) days** following the last day of the month in which the Member became ineligible.

D. If the addition of a Dependent to, or the deletion of a Dependent from, the Group's Contract affects the payments applicable to the Group, the new payment will take effect as follows:

   1. If the Dependent is added or deleted on or *before* the fifteenth of any month, the new payment is effective as of the **fifteenth** day of that month unless otherwise agreed to by the HMO and the Group.
   2. If the Dependent is added or deleted *after* the fifteenth of any month, the new payment is effective as of the first day of the following month unless otherwise agreed to by the HMO and the Group.

E. The HMO and the Group agree that the financial terms of this Contract are considered confidential and proprietary and shall not be disclosed by either party without the prior written approval of the other, except as required by law.

SECTION SR - SCHEDULE OF RATES

Please refer to the **"Confirmation of your new monthly premium rates" section of the "Important information about your new Group Contract" letter** for the Contract holder specific Contract Rates.

SECTION GA - GROUP APPLICATION

Application to:

Keystone Health Plan East, Inc.

whose main office address is

1901 Market Street,
Philadelphia, PA 19103

By: **CONTRACT HOLDER NAME**
CONTRACT HOLDER ADDRESS
CITY, STATE, ZIP CODE

For Group Contract Number(s): **CONTRACT NUMBER (S)** with an

Effective Date of Coverage **CONTRACT EFFECTIVE DATE** and an

Anniversary Date of **CONTRACT ANNIVERSARY** and will renew for a further period of twelve (12) consecutive months and thereafter, from year to year unless terminated as provided by this Contract provided required payments may be changed, as hereinafter provided, by Keystone with the approval of the Commonwealth of Pennsylvania; and for the coverage afforded by this Contract, and the terms of which are hereby approved and accepted by the Group to be executed and take effect on the Effective Date of Coverage shown above.

It is agreed that this Application supersedes any previous Application for this Contract.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SECTION BD - SCHEDULE OF BENEFITS DOCUMENT(S)

This Schedule of Benefit Documents sets forth the plan of benefits that apply to Members of the Group under this Contract as of the Effective Date of Coverage.

Subject to the exclusions, conditions and limitations set forth in the attached Member Handbook, a Member is entitled to benefits for Covered Services when: (a) deemed Medically Necessary; (b) provided or Referred by his or her Primary Care Physician; and (c) Preapproved by the HMO, where specified in the Member Handbook. Payment allowances for Covered Services are described in the **SCHEDULE OF COVERED SERVICES** attached to this Contract.

A copy of each Member Handbook, along with any Schedules, or additional coverage Riders (such as Dental, Prescription Drug and/or Vision, if applicable) reflecting the benefits purchased by the Group, will be attached here.

KEYSTONE HEALTH BENEFITS PLAN

By and Between

Keystone Health Plan East, Inc.
("Keystone" or "the HMO")*
*independent corporation operating under a license
from Blue Cross and Blue Shield Association
A Pennsylvania corporation
Located at:
1901 Market Street
P.O. Box 7516
Philadelphia, PA 19103-7516

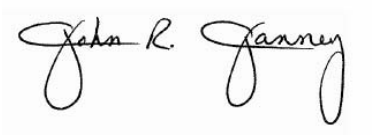
And
Group (Contract Holder)
(Called "the Group")

The HMO certifies that you (the enrolled Employee and your enrolled eligible Dependents, if any) are entitled to the benefits described in this Evidence of Coverage ("Handbook"), subject to the eligibility and effective date requirements.

This Handbook replaces any and all Handbooks previously issued to you under any group contracts issued by the HMO providing the types of benefits described in this Handbook.

The Contract is between the HMO and the Contract Holder. This Handbook is a summary of the provisions that affect your plan. All benefits and exclusions are subject to the terms of the Group Contract.

ATTEST:



John R. Janney
SVP Marketing Services

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INTRODUCTION

Thank you for joining the Keystone Health Benefits Plan. Our goal is to provide you with access to quality health care coverage. This Evidence of Coverage ("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 Handbook. Benefits, Exclusions and Limitations appear in the **EXCLUSIONS – WHAT IS NOT COVERED** and the **SCHEDULE OF COVERED SERVICES** section of this Handbook.

Please remember that this 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 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.

If changes are made to this plan, you will be notified. Changes will apply to benefits for services received on or after the effective date unless otherwise required by applicable law. The effective date is the later of:

A. The effective date of the change;

B. Your Effective Date of Coverage; or

C. The Group Master Contract's anniversary date coinciding with or next following that service's effective date.

Please read your 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 Customer Service Department ("Customer Service") at the telephone number shown on your ID Card.**

Any rights of a Member to receive benefits under the Contract and 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 be transferred, either before or after Covered Services are rendered. However, a Member can assign benefit payments to the custodial parent of a Dependent covered under the Contract and Handbook, as required by law.

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 responsible for applicable cost sharing or there may be limits on services as specified in the **SCHEDULE OF COVERED SERVICES** section of this Handbook. 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.

You can access most Covered Services directly without a Primary Care Physician's Referral. X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services must be 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.

Some Covered Services must be Preapproved before you receive the services. The Primary Care Physician or Participating 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 Participating Specialist provides Covered Services or Referrals without obtaining such Preapproval, you will not be responsible for payment. More information on Preapproval is found in **A Summary Of HMO Features** in the **GENERAL INFORMATION** section. To access a complete list of services that require Preapproval, log onto www.ibx.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.

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

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, for X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy 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. Additional Covered Services recommended by the Participating Specialist will require another 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 this HMO program for these Covered Services at any time after written notice of the change has been given to you.

Colorectal Cancer Screening

Colorectal cancer screening when performed by the Primary Care Physician or Referred Provider. Benefits are provided for the following Covered Services:

A. Screening fecal-occult blood or fecal immunochemical test;
B. Screening flexible sigmoidoscopy;
C. Screening colonoscopy;
D. Screening barium enema;
E. Screening test consistent with approved medical standards and practices to detect colon cancer.

Covered Services are provided to:

A. Symptomatic Member:
    1. A colonoscopy,
    2. Sigmoidoscopy or
    3. Any combination of colorectal cancer screening tests at a frequency determined by a treating physician.
B. Nonsymptomatic Members age fifty (50) years or older:
    1. An annual fecal occult blood test;
    2. A sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five (5) years.
    3. A colonoscopy at least once every ten (10) years.
C. Nonsymptomatic Members who are at high or increased risk for colorectal cancer who are under fifty (50) years of age:
    1. A colonoscopy or
    2. Any combination of colorectal cancer screening tests in accordance with the American Cancer Society current guidelines on screening for colorectal cancer.

Coverage shall be provided in accordance with American Cancer Society current guidelines for colorectal cancer screenings, and consistent with approved medical standards and practices.

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.

Nutrition Counseling for Weight Management

Benefits are provided for nutrition counseling visits/sessions for the purpose of weight management when performed and billed by your network physician, Specialist or a Registered Dietitian (RD) in an office setting.

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

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.

Routine Gynecological Exam, Pap Smear

Female Members are covered for one (1) routine gynecological exam each benefit period. 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.

INPATIENT 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.

To access a complete list of services that require Preapproval, log onto www.ibx.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.

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. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Additional Covered Services recommended by the Participating Specialist will require another 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; and
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 Participating 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 Participating 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 Participating 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 this HMO program.

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 to make sure that you have a smooth transition from the facility to home or other setting. An HMO Case Manager will work closely with your Primary Care Physician or the Participating Specialist to help with your discharge and if necessary, arrange for other medical services.

Should your Primary Care Physician or Participating 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. You may appeal this decision through the Grievance appeal process.

INPATIENT/OUTPATIENT 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.

To access a complete list of services that require Preapproval, log onto www.ibx.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.

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. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Additional Covered Services recommended by the Participating Specialist will require another 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 Participating 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 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 Participating 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 Participating Specialist that is a Physician or a certified nurse midwife. Benefits are also payable for certain services provided by Participating 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 SERVICES**.

B. Abortions

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

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 **Eligibility, Change And Termination Rules Under The Plan** in the **GENERAL INFORMATION** section of this Handbook.

D. Artificial Insemination

Facility services provided by a Participating Facility Provider and services performed by a Participating 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 as shown in the **SCHEDULE OF COVERED SERVICES** included with this Handbook.

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; and

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. All Intensive Outpatient Program and Partial Hospitalization services must be approved by the HMO.

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, this HMO program 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, a Psychologist, a registered or Licensed Practical Nurse, and/or a 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 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:

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

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

c. Rehabilitation therapy and counseling;

d. Family counseling and intervention; and

e. 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.

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.

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 E and F 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 Participating Specialist other than the surgeon, assistant surgeon or attending Participating 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 Participating 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 by a donor to a human transplant recipient:

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

B. When only the recipient is a Member, both the donor and the recipient are entitled to the benefits of the 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.

C. When only the donor is a Member, the donor is entitled to the benefits of the Handbook, subject to following additional limitations:

   1. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of the Handbook; and

   2. No benefits will be provided to the non-Member transplant recipient.

D. 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:

   1. Removal of the organ;

   2. Preparatory pathologic and medical examinations; and

   3. Post-surgical care.

OUTPATIENT SERVICES

Services for Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by the HMO.

To access a complete list of services that require Preapproval, log onto www.ibx.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.

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. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Additional Covered Services recommended by the Participating Specialist will require another electronic Referral from your Primary Care Physician.

Ambulance Services

Benefits are provided for ambulance services that are Medically Necessary, as determined by this HMO program, 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 item "1. For Emergency Ambulance transport" or item "2. 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

Benefits 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 non-insulin-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 Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to requirements 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 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. 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.

A. Diabetic Equipment
    1. Blood glucose monitors;
    2. Insulin pumps;
    3. Insulin infusion devices; and
    4. Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

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
9. Glucagon emergency kits.

Diagnostic Services

The following Diagnostic Services when ordered by a Participating Professional Provider and billed by a Participating 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), Computed Tomography (CT Scan);

C. Diagnostic laboratory and pathology tests; and

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 this HMO program, 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.

Replacement and repair: Benefits are provided for the repair or replacement of DME when the equipment does not function properly and is no longer useful for its intended purpose when:

A. A change in your condition requires a change in the DME this HMO program will provide repair or replacement of the DME.

B. The DME is broken due to significant damage, defect, or wear, this HMO program will provide repair or replacement only if the DME’s warranty has expired and it has exceeded its reasonable useful life as determined by this HMO program.

If the DME breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are:

A. This HMO program's responsibility in the case of rented equipment; and,

B. Your responsibility in the case of purchased equipment.

This HMO program is not responsible if the DME breaks during its reasonable useful lifetime for any reason not covered by warranty, For example, no benefits are provided for repairs and replacements needed because the equipment was abused or misplaced.

Benefits are provided to repair DME when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of DME, replacement means the removal and substitution of DME or one of its components necessary for proper functioning. A repair is a restoration of the DME or one of its components to correct problems due to wear or damage or defect.

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 E 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 cost sharing 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 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.ibx.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 COVERED SERVICES**.

(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.

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 Participating 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 or a Participating Specialist as a part of a 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:

      a. Accidental Injury;

      b. Trauma; or

      c. 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 Participating 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 this HMO program. 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 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.

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.

Vision Care

Vision screening to determine the need for refraction when performed by your Primary Care Physician.

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 Customer Service.

Office Visit Copay: $0

EMERGENCY AND URGENT CARE

WHAT ARE EMERGENCY SERVICES?

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

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 Keystone'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 that includes X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services. 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 Participating Specialist.

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

Note: It is your responsibility to contact the HMO for any bill you receive for Emergency Services or out-of-area Urgent Care provided by a Non-Participating Provider. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on your ID card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

MEDICAL SCREENING EVALUATION

Medical Screening Evaluation services will be Covered Services when performed in a Hospital emergency department for the 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 Group's 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 Keystone'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.

WHAT IS FOLLOW-UP CARE?

"Follow-Up Care" is Medically Necessary follow-up visits that occur while you are outside Keystone's Service Area. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while you are in Keystone'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 Keystone's Service Area.

ACCESS TO COVERED SERVICES OUTSIDE KEYSTONE'S SERVICE AREA

Members have access to health care services when traveling outside of Keystone Service Area. The length of time that you will be outside the Service Area will determine whether benefits will be available through the BlueCard Program or the Away From Home Care Guest Membership Program.

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

THE BLUECARD®PROGRAM

Through the BlueCard Program, Urgent Care Benefits cover Medically Necessary treatment for any unforeseen illness or injury that requires treatment prior to when you return to the Keystone's Service Area. Covered Services for Urgent Care are provided by a contracting Blue Cross and Blue Shield Association traditional participating Provider ("BlueCard Provider"). Coverage is for Medically Necessary services required to prevent serious deterioration of the Member's health while traveling outside Keystone's Service Area during a temporary absence (less than 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 Away From Home Care Guest Membership Program (see below).

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.

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 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-ASK-BLUE to get prior authorization for the service from Keystone.
- With Keystone's approval, you call the Provider to schedule an appointment. The BlueCard Provider confirms Member eligibility.
- You show your ID Card when seeking services from the BlueCard Provider.
- You pay the Copayment at the time of your visit.

Follow-Up Care Benefits under the BlueCard Program

Follow-Up Care Benefits under the BlueCard Program cover Medically Necessary Follow-Up Care required while 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 and the health plan in Keystone's Service Area prior to leaving the Service Area. Under the BlueCard Program, coverage is provided only for the specified, Preapproved service(s) authorized by 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-ASK-BLUE to get prior authorization for the service from Keystone. If a BlueCard 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 Providers.
- Upon deciding which BlueCard 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 Provider to schedule an appointment.
- The BlueCard Provider confirms your eligibility.
- You show your ID Card when seeking services from the BlueCard Provider.
- You pay the Copayment at the time of your visit.

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.

THE AWAY FROM HOME CARE®PROGRAM

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. As a Guest Member, your Guest Membership Benefits are provided by the local Blue Cross Plan participating 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 Keystone's Service Area for more than ninety (90) days (student); or
- Your Dependent lives apart from you and is outside Keystone's 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 Customer Service 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 Customer Service number on the ID card to determine if arrangements can be made for Student Guest Membership Benefits for your dependent.

The Away From Home Care Program provides Guest Membership Benefits coverage for a wide range of health care services including Hospital care, routine physician visits, and other services. Guest Membership Benefits are available only when 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 in Keystone's Service Area 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 Customer Service at the telephone number shown on the ID Card.

This 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 this HMO program, you must contact Customer Service 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 Group plan. For direct billing, the Provider should mail the bill to the address in the next sentence. If direct billing cannot be arranged, send us a letter explaining the reason care was needed and an original itemized bill to:

Keystone Health Plan East
P.O. Box 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.

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 COVERED SERVICES** sections, only until you can, without medically harmful consequences, be transferred to the care of your Primary Care Physician or a Participating Specialist designated by your Primary Care Physician.

All continuing care that includes X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services must be provided by your Primary Care Physician or coordinated through Customer Service.

AUTO OR WORK-RELATED ACCIDENTS

Motor Vehicle Accident

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

REMEMBER: This HMO program will always be secondary to your auto insurance coverage. However, in order for services to be covered by this HMO program as secondary, your care must be provided by your Primary Care Physician or a Participating Provider.

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 Customer Service as soon as possible and advise us that you have been involved in a motor vehicle accident. This information helps the HMO to coordinate this HMO program's benefits with coverage provided through your auto insurance company.

Only services provided by your Primary Care Physician or Participating Providers will be covered by this HMO program.

Work-Related Accident

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

REMEMBER: **This HMO program will always be secondary to your Worker's Compensation coverage. However, in order for services to be covered by this HMO program as secondary, your care must be provided by your Primary Care Physician or a Participating Provider.**

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 Customer Service as soon as possible and advise us that you have been involved in a work-related accident. This information helps the HMO to coordinate this HMO program benefits with coverage provided through your employer's Worker's Compensation coverage.

Only services provided by your Primary Care Physician or Participating Providers will be covered by this HMO program.

SCHEDULE OF COVERED SERVICES

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

If the Participating Provider's usual fee for a Covered Service is less than the Coinsurance, Copayment or Deductible 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, Copayment or Deductible overpayment directly to you. If you have any questions, contact Customer Service at the phone number on your ID Card.

Your Primary Care Physician or Specialist must obtain Preapproval from the HMO to confirm this HMO program'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. To access a complete list of services that require Preapproval, log onto www.ibx.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.

Please refer to your **"Important information about your new group contract"** letter for the Subscriber-specific Benefit Period.

ANNUAL DEDUCTIBLE

Per Member	$2,000
Per Family	$6,000

ANNUAL OUT-OF-POCKET MAXIMUM

Per Member	$3,000
Per Family	$9,000

COINSURANCE PERCENTAGE	20% of the Allowed Amount
LIFETIME BENEFIT MAXIMUM	Unlimited

Coinsurance is a percentage of the Covered Service that must be paid by the Member; it is applied after the Deductible is met. Coinsurance is applied to some of the Covered Services listed below, but not to Covered Services that require the Member to pay a Copayment amount. Covered Services that require the Member to pay a Copayment amount are not subject to Deductibles.

The Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Deductible for that benefit period, or the Family Deductible has been satisfied for all covered family Members combined.

The Member will also be responsible to pay costs for services that are not covered by the HMO plan.

PRIMARY AND PREVENTIVE CARE

BENEFIT	COST SHARING
ADULT PREVENTIVE CARE	$0
MAMMOGRAMS	$0
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT Six (6) outpatient nutrition counseling visits/sessions per benefit period	$0
OFFICE VISITS TO YOUR PCP (Non-Preventive) (Includes Home Visits and Outpatient Consultations)	$20 per visit
OFFICE VISITS TO A SPECIALIST	$40 per visit
PEDIATRIC IMMUNIZATIONS (Birth to age 21)	$0
PEDIATRIC PREVENTIVE CARE	$0
ROUTINE GYNECOLOGICAL EXAMINATION (Includes Pap Smear one (1) per benefit period, all ages)	$0

INPATIENT SERVICES

BENEFIT	COST SHARING
HOSPITAL SERVICES	20% of the Allowed Amount
MEDICAL CARE	$0
SKILLED NURSING CARE FACILITY Maximum of one hundred twenty (120) Inpatient days per benefit period.	20% of the Allowed Amount

INPATIENT/OUTPATIENT SERVICES

BENEFIT	COST SHARING
BLOOD	$0
HOSPICE SERVICES	
Inpatient Hospice Services	20% of the Allowed Amount
Outpatient Hospice Services	
Professional Service	20% of the Allowed Amount
Facility Service for Respite Care	20% of the Allowed Amount
Respite Care is provided for a maximum of seven (7) days every six (6) months.	
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES	
Artificial Insemination	$20 per visit
Elective Abortions	
Professional Service	$20
Facility Services	20% of the Allowed Amount
Newborn Care	$0
Non-Routine Maternity/Obstetrical Care	
Professional Service	$20 first visit only
Facility Services	20% of the Allowed Amount

INPATIENT/OUTPATIENT SERVICES
(Continued)

BENEFIT	COST SHARING

MENTAL HEALTH CARE

Inpatient Mental Health Care Admissions — 20% of the Allowed Amount

Thirty (30) Inpatient days per benefit period

Outpatient Mental Health Care Visits/Sessions — $40 per visit/session

Twenty (20) outpatient visits/sessions per benefit period

Up to thirty (30) Inpatient days may be exchanged for up to sixty (60) outpatient visits/sessions per benefit period

SERIOUS MENTAL ILLNESS HEALTH CARE

Inpatient Serious Mental Illness Health Care Admissions — 20% of the Allowed Amount

Thirty (30) Inpatient days per benefit period

Outpatient Serious Mental Illness Health Care Visits/Sessions — $40 per visit/session

Sixty (60) outpatient visits/sessions per benefit period

Each available Inpatient day maybe exchanged for two (2) additional outpatient visits/sessions per benefit period.

SUBSTANCE ABUSE TREATMENT

Inpatient Substance Abuse Admissions — 20% of the Allowed Amount

Thirty (30) Inpatient days per benefit period in a Department of Health licensed substance abuse treatment program at a Participating Facility Provider that is a Behavioral Health/Substance Abuse Provider.

Lifetime Benefit Maximum: ninety (90) days

Up to thirty (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 benefit period. These additional Inpatient days are considered a part of the Inpatient Lifetime Maximum days.

INPATIENT/OUTPATIENT SERVICES
(Continued)

BENEFIT	COST SHARING
Outpatient Substance Abuse Treatment Visits/Sessions (including Outpatient Detoxification)	$40 per visit/session
Sixty (60) outpatient visits/sessions per benefit period	
Lifetime Benefit Maximum of one hundred twenty (120) visits/sessions	
Detoxification Services	
Inpatient Detoxification Services Admissions	20% of the Allowed Amount
Inpatient treatment limited to seven (7) days per admission	
Lifetime Benefit Maximum of four (4) admissions	
SURGICAL SERVICES	
Outpatient Facility Charges	20% of the Allowed Amount
Outpatient Anesthesia	$0
Voluntary Second Surgical Opinion	$40 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.

OUTPATIENT SERVICES

BENEFIT	COST SHARING
AMBULANCE	
Emergency Transport and Non-Emergency Transport	20% of the Allowed Amount
DAY REHABILITATION PROGRAM	
Outpatient Visits	20% of the Allowed Amount
Thirty (30) sessions per benefit period	
DIABETIC EDUCATION PROGRAM	$0
Coinsurance, Copayments, Deductibles and Maximum amounts do not apply to this benefit.	
DIABETIC EQUIPMENT AND SUPPLIES	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
DIAGNOSTIC SERVICES	
Routine Diagnostic Services	$40 per date of service
Non-Routine Diagnostic Services (including MRI/MRA, CT scans, PET scans)	$80 per date of service
Laboratory and Pathology Tests	$0
DURABLE MEDICAL EQUIPMENT	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
EMERGENCY CARE –Emergency Care Services	20% of the Allowed Amount

The emergency room coinsurance will be the PCP office visit Copayment if you notify us that you were directed to the emergency room by your Primary Care Physician or the HMO, and the services could have been provided in your Primary Care Physician's office.

HOME HEALTH CARE	20% of the Allowed Amount
Unlimited visits	

OUTPATIENT SERVICES
(Continued)

BENEFIT	COST SHARING
INJECTABLE MEDICATIONS	
Specialty Injectable Drugs	$100
Standard Injectable Drugs	$0
MEDICAL FOODS AND NUTRITIONAL FORMULAS	$0
PRIVATE DUTY NURSING SERVICES	20% of the Participating Provider's contracted fee schedule amount
Three hundred sixty (360) hours per benefit period	

OUTPATIENT SERVICES
(Continued)

BENEFIT	COST SHARING
PROSTHETIC DEVICES	50% of the Participating Provider's contracted fee schedule amount per device
SPINAL MANIPULATION SERVICES	$40 per visit
Twenty (20) visits per benefit period	
THERAPY SERVICES	
Cardiac Rehabilitation Therapy	$40 per visit
Thirty-six (36) sessions per benefit period	
Chemotherapy	20% of the Allowed Amount
Dialysis	20% of the Allowed Amount
Infusion Therapy	20% of the Allowed Amount
Orthoptic/Pleoptic Therapy	$40 per visit
Lifetime Maximum: eight (8) sessions	
Physical Therapy / Occupational Therapy	$40 per visit
Thirty (30) visits per benefit period	
There is no limit for lymphedema therapy related to a mastectomy.	
Pulmonary Rehabilitation Therapy	$40 per visit
Thirty-six (36) sessions per benefit period	
Radiation Therapy	20% of the Allowed Amount
Speech Therapy	$40 per visit
Twenty (20) visits per benefit period	

EXCLUSIONS - WHAT IS NOT COVERED

The following are excluded from your coverage:

1. Services, supplies or charges which are:

   A. Not provided by the Member's Primary Care Physician, Referred Provider or by a Participating Provider except in an Emergency or as specified elsewhere in this Handbook;

   B. Not Medically Necessary, as determined by the Primary Care Physician and/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. For any loss sustained or expensed 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;

3. Any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Developmental Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, intellectual disability, or treatment or care to effect environmental or social change except as otherwise provided in this HMO program;

4. 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;

5. Ambulance service, unless Medically Necessary;

6. 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. Nutritional supplements are provided when the Member has no other source of nutritional intake due to a metabolic or anatomic disorder;

7. The cost of 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;

8. 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;

9. 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);

10. The cost of Hospital, medical or any other health services for injuries resulting from a motor vehicle accident if the costs are payable under a plan or policy of motor vehicle insurance or under any medical expense payment provision including a certified self-insured plan, unless otherwise prohibited by law;

11. 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 this HMO program 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;

12. For care in a nursing home, home for the aged, convalescent home, school, camp, institution for intellectually disabled children, Custodial Care in a Skilled Nursing Facility;

13. With respect to Dental Care:

    A. 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 and 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;

    B. For dental implants for any reason;

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

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

    E. For oral devices used for temporomandibular joint syndrome or dysfunction;

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

14. Services received from a dental or medical department maintained by an employer, mutual benefit association, labor union, trust or similar person;

15. With respect to Durable Medical Equipment (DME), 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 for environmental control. Items not covered include, but are not limited to: air cleaners; air conditioners; dehumidifiers; portable room heaters; and ambient heating and cooling equipment.

    C. That is inappropriate for home use. This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes.

    D. 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; lamb's wool pads; ace bandages; catheters (non-urinary); face masks (surgical); disposable gloves, sheets and bags; and irrigating kits.

    E. 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.

    F. 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.

    G. 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.

    H. 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.

    I. 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.

16. Charges in excess of benefit maximums;

17. 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, or 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 and deemed Medically Necessary by your Primary Care Physician, specialist or the HMO;

18. Equipment costs related to services performed on high cost technological equipment unless the acquisition of such equipment was approved through a Certificate of Need process and/or the HMO;

19. 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 conditioners and similar services, appliances and 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.

20. For health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents;

21. 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;

22. Immunizations required for employment purposes or travel;

23. Any charges for services, supplies or treatment while a Member is incarcerated in any adult or juvenile penal or correctional facility or institution;

24. Services Incurred prior to the Member's effective date;

25. Services which were or are Incurred after the date of termination of the Member's coverage, except as provided in this Handbook;

26. 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;

27. Charges for completion of any insurance form;

28. Care for conditions that federal, state or local law requires to be treated in a public facility;

29. For Maintenance of chronic conditions, injuries or illness; also excluded are services and supplies for the Maintenance of chronic conditions;

30. Marriage or religious counseling;

31. 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;

32. 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 except as otherwise provided in this HMO program;

33. Services, charges or supplies for which a Member would have no legal obligation to pay, or another party has primary responsibility;

34. Non-medical services, such as vocational rehabilitation or employment counseling, for the treatment of Substance Abuse in an acute care Hospital;

35. Charges not billed/performed by a Provider;

36. 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 Handbook;

37. Services required by a Member donor related to organ donation. Expenses for donors donating organs to Member recipients are covered only as provided in the Contract and described in this Handbook. No payment will be made for human organs which are sold rather than donated;

38. 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;

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. Personal or comfort items such as television, telephone, air conditioners, humidifiers, barber or beauty service, guest service and similar incidental services and supplies which are not Medically Necessary;

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

43. Services for repairs or replacements of Prosthetic Devices needed because the prosthesis was abused or misplaced;

44. Hearing or audiometric examinations, and 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;

45. 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.

46. 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;

47. 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;

48. Counseling with patient's relatives except as may be specifically provided in the **DESCRIPTION OF COVERED SERVICES** section entitled "Substance Abuse Treatment" or "Transplant Services";

49. Reversal of voluntary sterilization and services required in connection with such procedures;

50. Services or supplies which are Experimental or Investigational, except Routine Costs Associated With Qualifying Clinical Trials that have been Preapproved by the HMO.

    Services that are not Routine costs and are not covered include 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 Subscriber in the Qualifying Clinical Trial.

51. 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;

52. Any charges for the administration of injectable insulin;

53. With regard to drugs and Medications:

    A. The following, except if covered by the Prescription Drug addendum:

        1. Outpatient Prescription Drugs; and

        2. Contraceptive Drugs and devices;

    B. Medications that may be dispensed without a doctor’s prescription;

54. Any drugs covered by the Prescription Drug addendum, or under a free-standing prescription drug agreement issued under the plan;

55. Injectable medications except those necessary for the immediate treatment of an injury or acute illness when provided or Referred by your Primary Care Physician and administered in the Physician's office. Injectable medications are covered under the Prescription Drug addendum;

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

57. For Self-Injectable Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered Self-Injectable Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration.

    Self-injectable Drugs are covered by the Prescription Drug addendum or freestanding prescription drug contract issued by the HMO or its affiliates.

    Self-Injectable Drugs will not be covered unless they are required for treatment of an emergency condition that requires a Self-Injectable Prescription Drug.

58. Any charge where the usual and customary charge is less than the Member's Insulin or oral agent cost-sharing amount;

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

60. For any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations except for sickness or injury resulting from such Surgery;

61. 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;

62. Any therapy service provided for:

    A. Ongoing outpatient treatment of chronic medical conditions that are not subject to significant functional improvement;

    B. Additional therapy beyond this HMO program's day limits, if any, shown on the **SCHEDULE OF COVERED SERVICES**;

    C. Work hardening;

    D. Evaluations not associated with therapy; or

    E. Therapy for back pain in pregnancy without specific medical conditions;

63. 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;

64. Vision care which is covered under the Vision addendum, 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;

    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.

65. Customized wheelchairs;

66. 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 nutrition counseling visits/sessions as described in the Nutrition Counseling for Weight Management provision in this Handbook;

67. The cost of services or supplies 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, employer's liability laws, or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Member claims the benefits or compensation;

68. Any services, supplies or treatments not specifically listed as covered benefits in the Contract and Handbook, 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.

OTHER ANCILLARY SERVICES

PRESCRIPTION DRUG

SUMMARY OF PRESCRIPTION DRUG FEATURES

Prescription Drug benefits will be available for Covered Drugs Or Supplies dispensed by a Prescription Order Or Refill for use when you are not an inpatient. Benefits for Covered Drugs Or Supplies are subject to cost sharing as shown on the **PRESCRIPTION DRUG SCHEDULE OF COVERED SERVICES** and in the Prescription Drug Limitations section.

In certain cases, the HMO may determine that the use of certain Covered Drugs Or Supplies for a Member's medical condition requires Preapproval for Medical Necessity.

In certain cases where the HMO determines there may be Prescription Drug usage by a Member that exceeds what is generally considered appropriate under the circumstances, the HMO shall have the right to direct that Member to one Pharmacy for all future Covered Drugs Or Supplies.

After you satisfy the Prescription Drug Deductible (except for lancets and glucometers), the HMO reimburses for Covered Drugs or Supplies as follows:

- **Drugs From a Participating Pharmacy** - Covered Drugs Or Supplies furnished by a Participating Pharmacy without charge except for the Prescription Drug Copay for each Prescription Order Or Refill. Cost sharing, Limitations, or maximums are listed on the **PRESCRIPTION DRUG SCHEDULE OF COVERED SERVICES**.
- **Drugs From a Non-Participating Pharmacy** - Covered Drugs Or Supplies furnished by a Non-Participating Pharmacy when you submit acceptable proof of payment with a direct reimbursement form. Reimbursement for Covered Drugs Or Supplies will not exceed thirty percent (30%) of the usual and customary charge. You will be entitled to reimbursement only if your purchase is related to Covered Services for Emergency Care or Urgent Care out of the Service Area. The Member must submit acceptable proof of payment with a direct reimbursement form. All claims for payment must be received within ninety (90) days of the date of proof of purchase. Direct reimbursement forms may be obtained by contacting the Customer Service Department.
- **Drugs From a Participating Mail Service Pharmacy** – Covered Drugs Or Supplies furnished by a Participating Mail Service Pharmacy subject to the Prescription Drug cost sharing for each Prescription Order or Refill.
- **Vitamins** that require a Prescription Order or Refill.
- **Prescribing Physician** - Covered Drugs Or Supplies, and covered Maintenance Prescription Drugs Prescribed by your Primary Care Physician or Referred Specialist, and furnished by a Participating Pharmacy. Generically equivalent pharmaceuticals will be dispensed whenever applicable. Prescription Drugs contained in the Drug Formulary will be Prescribed and dispensed whenever appropriate, pursuant to the professional judgment of the Primary Care Physician, Referred Specialist and/or the Pharmacist. Covered Drugs not listed in the Drug Formulary shall be subject to the Non-Formulary Drug Copay. To obtain a copy of the Formulary, the Member should call Customer Service at the phone number shown on the ID Card.

- **Over-the Counter Drugs** - Prescription Drug Benefits do not cover over-the-counter drugs except insulin.

- **Insulin -** only by Prescription Order Or Refill. Coverage includes, insulin, disposable insulin needles and syringes, diabetic blood testing strips, lancets and glucometers. There is no Prescription Drug cost sharing requirement for lancets and glucometers obtained through a Participating Pharmacy or a Participating Mail Service Pharmacy.
- **Dermatological Drugs** - Compounded dermatological preparations containing at least one Federal Legend or State Restricted Drug.
- **Self-Injectable Medications** – Benefits are provided for Self-Injectable Covered Drugs Or Supplies.

The HMO requires Preapproval (by the Member's Physician) for certain drugs to ensure that the prescribed drug is medically appropriate. Where Preapproval or quantity level limits are imposed, the Member's Physician may request an exception for coverage by providing documentation of Medical Necessity. The Member may obtain information about how to request an exception by calling Customer Service at the phone number on the ID Card.

The Member, or his or her Physician acting on their behalf, may appeal any denial of benefits through the Complaint Appeal and Grievance Appeal Process described in the Handbook.

INFORMATION ABOUT PROVIDER REIMBURSEMENT

Pharmacy

A pharmacy benefits management company (PBM), which is affiliated with the HMO, administers our Prescription Drug benefits, and is responsible for providing a network of Participating Pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The HMO anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of Prescription Drug benefits. Under most benefit plans, Covered Drugs Or Supplies are subject to the Member’s cost-sharing.

PRESCRIPTION DRUG EXCLUSIONS

The following are excluded from your Prescription Drug benefits:

1. Devices of any type, even though such devices may require a Prescription Order Or Refill. This includes, but is not limited to, contraceptive devices, therapeutic devices or appliances, hypodermic needles, syringes or similar devices, support garments or other devices, regardless of their intended use, except as specified as a benefit in this HMO program. This exclusion does not apply to devices (a) used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and (b) devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines;

2. Drugs Prescribed and administered in the Physician's office;

3. Drugs which do not by Federal or State law require a Prescription Order (i.e., over-the-counter) or drugs that require a Prescription Order but have an over-the-counter equivalent, except insulin and drugs specifically designated by the HMO, whether or not Prescribed by a Physician;

4. Any drugs already listed as covered in your Handbook;

5. Prescription Drugs covered without charge under Federal, State or local programs including Worker's Compensation and Occupational Disease laws;

6. Medication for a Member confined to a rest home, Skilled Nursing Facility, sanitarium, extended care facility, Hospital or similar entity;

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

8. Covered Drugs Or Supplies administered at the time and place of the Prescription Order;

9. Any charges for the administration of Prescription Legend Drugs or injectable insulin;

10. Prescription Drugs dispensed by Non-Participating Pharmacies, except as specified in the Summary of Prescription Drug Features;

11. Prescription Refills resulting from loss or theft, or any unauthorized Refills;

12. Immunization agents, biological sera, blood or plasma, or allergy serum;

13. Experimental Or Investigational Drugs, and drugs Prescribed for experimental (non-Food and Drug Administration approved) indications;

14. Drugs used for cosmetic purposes, including but not limited to, anabolic steroids, minoxidil lotion, and Retin A (tretinoin), when used for non-acne related conditions. However, this exclusion does not include drugs prescribed to treat medically diagnosed congenital defects and birth abnormalities;

15. Nicotine patches or gum or any other pharmacological therapy for smoking cessation;

16. Pharmacological therapy for weight reduction or diet agents unless Preapproved by the HMO;

17. Any charge where the usual and customary charge is less than the Member's Prescription Drug cost sharing;

18. Injectable drugs, including injectable drugs used for the primary purpose of treating infertility or injectable drugs for fertilization. This exclusion does not include injectable Contraceptive Drugs if covered under the plan or injectables that are otherwise not covered under the plan;

19. Prescription Drugs not approved by the HMO or Prescribed drug amounts exceeding the quantity level limits as conveyed by the Food and Drug Administration (FDA) or the HMO's Pharmacy and Therapeutics Committee;

REMEMBER: Refer to the Complaint Appeal and Grievance Appeal Process section in your Handbook for information about addressing any questions or resolving any problems you may have. (Example: The denial of coverage for a Prescription Drug.)

PRESCRIPTION DRUG IMPORTANT DEFINITIONS

For the purpose of understanding your Prescription Drug benefits, the terms below have the following meaning:

BRAND NAME DRUG - a single source, FDA approved drug manufactured by one company for which there is no FDA approved substitute available. The term "Brand Name Drug" shall also mean devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

CONTRACEPTIVE DRUGS - FDA approved drugs requiring a Prescription Order Or Refill to be dispensed for the use of contraception. These include oral contraceptives, such as birth control pills, as well as injectable contraceptive drugs. This does not include implants.

CONTROLLED SUBSTANCE - any medicinal substance as defined by the Drug Enforcement Administration which requires a Prescription Order Or Refill in accordance with the Controlled Substance Act-Public Law 91-513.

COVERED DRUGS OR SUPPLIES – drugs, including Self-Injectable Prescription Drugs, or supplies approved under Federal Law by the FDA for general use, and limited to the following:

A. Prescription Drugs Prescribed by a Primary Care Physician or Referred Specialist subject to the Prescription Drug Exclusions, and other exclusions listed in the Handbook or made part of this HMO program;

B. Compounded Prescription Drugs containing at least one Legend Drug or Controlled Substance in an amount requiring a Prescription Order Or Refill;

C. Insulin (by Prescription Order Or Refill only); or

D. Spacers for metered dose inhalers (by Prescription Order Or Refill only).

DRUG FORMULARY - a listing of Prescription Drugs preferred for use. This list shall be subject to periodic review and modification by the HMO. Covered Drugs not listed in the Drug Formulary shall be subject to the Non-Formulary Drug Copay.

EXPERIMENTAL OR INVESTIGATIONAL DRUGS - pharmacological regimens not generally accepted by the American medical community or approved by the FDA.

GENERIC DRUG - a Prescription Drug 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.

LEGEND DRUG - a Prescription Drug which is required by the Federal Food, Drug, and Cosmetic Act to be labeled as follows: "Caution: Federal Law prohibits dispensing without a prescription."

MAINTENANCE PRESCRIPTION DRUG - a Prescription Drug, as determined by the HMO, used for the treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis.

MULTI-SOURCE DRUG - a branded FDA approved Prescription Drug for which an FDA approved Generic Drug substitute is available.

NON-FORMULARY DRUG – a Prescription Drug not included in the Drug Formulary.

NON-PARTICIPATING PHARMACY - a pharmacy (whether a retail or mail service pharmacy) which has not entered into a written agreement with the HMO or an agent of the HMO to provide Covered Drugs Or Supplies to Members.

PARTICIPATING MAIL SERVICE PHARMACY - a registered, licensed pharmacy with whom the HMO or an agent of the HMO has contracted to provide Covered Drugs Or Supplies through the mail and to accept as payment in full the HMO payment plus any applicable Prescription Drug cost sharing amount for the Covered Drugs Or Supplies.

PARTICIPATING PHARMACY - any registered, licensed pharmacy other than a Participating Mail Service Pharmacy with whom the HMO or an agent of the HMO has contracted to dispense Covered Drugs Or Supplies to Members and to accept as payment in full the HMO payment plus any applicable Prescription Drug cost sharing amount for the Covered Drugs Or Supplies.

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.

PREAPPROVAL (PREAPPROVED) – the Preapproval which the Primary Care Physician or Referred Specialist must obtain from the HMO to confirm Medical Necessity for certain Covered Drugs Or Supplies for a Member's medical condition. Such Preapproval must be obtained prior to providing the Covered Drug Or Supply. The HMO also reserves the right to apply eligible dispensing limits for certain Covered Prescription Drugs Or Supplies as conveyed by the FDA or the HMO's Pharmacy and Therapeutics Committee. The Member may call Customer Service at the telephone number shown on the ID Card to find out if the Covered Drug Or Supply has been approved by the HMO or may ask the Primary Care Physician to call Provider Services.

PRESCRIBE OR PRESCRIBED - to write or give a Prescription Order.

PRESCRIPTION DRUG - a Legend Drug or Controlled Substance, subject to the exclusions listed in the Handbook or made part of this HMO program (including those listed in the Prescription Drug Exclusions) which has been approved by the FDA for a specific use and which can, under Federal or State Law, be dispensed only pursuant to a Prescription Order Or Refill and only by a licensed Pharmacist. This definition includes insulin and spacers for metered dose inhalers obtained with a Prescription Order Or Refill.

PRESCRIPTION DRUG COPAYMENT (DRUG COPAY) - the amount as shown in the **PRESCRIPTION DRUG SCHEDULE OF COVERED SERVICES** charged to the Member by the Participating Pharmacy or Participating Mail Service Pharmacy for the dispensing or refilling of any Prescription Order Or Refill. The Member is responsible at the time of service for payment of the Drug Copay directly to the Participating Pharmacy or Participating Mail Service Pharmacy.

PRESCRIPTION DRUG DEDUCTIBLE – the dollar amount of Covered Drugs Or Supplies that a Member must pay in a benefit period before any Prescription Drug Coinsurance is applied.

PRESCRIPTION ORDER OR REFILL - the authorization for a Prescription Drug issued by a Primary Care Physician or Referred Specialist who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

SELF-INJECTABLE PRESCRIPTION DRUG (SELF-INJECTABLE DRUG) – a Prescription Drug that: (a) is introduced into a muscle or under the skin by means of a syringe and needle; and (b) can be administered safely and effectively by the patient or caregiver outside of medical supervision regardless of whether initial medical supervision and/or instruction is required; and (c) is administered by the patient or caregiver.

STATE RESTRICTED DRUG - a non-Federal Legend Drug which, according to State law, may not be dispensed without a Prescription Order Or Refill.

PRESCRIPTION DRUG LIMITATIONS

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

2. The quantity of a Covered Prescription Drug dispensed per Prescription Drug Copay from a pharmacy pursuant to a Prescription Order Or Refill is limited to thirty (30) consecutive days or the maximum allowed dosage as prescribed by law, whichever is less.

   Up to a ninety (90) day supply of a Maintenance Prescription Drug may be obtained through a Participating Pharmacy for two (2) times the Prescription Drug Copay.

   Up to a ninety (90) day supply of a Covered Maintenance Prescription Drug may be obtained through a Participating Mail Service Pharmacy for two (2) times the cost sharing amount as shown on the **PRESCRIPTION DRUG SCHEDULE OF COVERED SERVICES**.

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

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

5. You must present your ID Card, and the existence of Prescription Drug Coverage must be indicated on the card.

6. You will pay to a Participating Pharmacy:

   A. One hundred percent (100%) of the cost for a Prescription Drug dispensed when you fail to show your ID Card. A claim for reimbursement for Covered Drugs Or Supplies may be submitted to the HMO; or

   B. One hundred percent (100%) of a non-Covered Drug Or Supply; or

   C. The Prescription Drug cost sharing as specified in the **PRESCRIPTION DRUG SCHEDULE OF COVERED SERVICES**.

7. In certain cases the HMO may determine that the use of a certain Covered Drug Or Supply for a Member’s medical condition requires Preapproval for Medical Necessity.

8. The HMO reserves the right to apply eligible dispensing limits for certain Covered Prescription Drugs as conveyed by the FDA or the HMO’s Pharmacy and Therapeutics Committee.

PRESCRIPTION DRUG SCHEDULE OF COVERED SERVICES

BENEFIT	COST SHARING/LIMITATION
PRESCRIPTION DRUG DEDUCTIBLE	$250 of Covered Services incurred by a Member in one benefit period for Covered Prescription Drugs purchased at a Participating Pharmacy or Participating Mail Service Pharmacy. The Prescription Drug Deductible must be satisfied by the Member before applicable Copayment amounts are applied.
PARTICIPATING PHARMACY	
Generic Formulary Drug	$20
Brand Formulary Drug	$40
Non-Formulary Drug	$60
PARTICIPATING MAIL SERVICE PHARMACY	
The amount of your cost sharing is determined by the days-supply you receive of Covered Maintenance Drug:	
FOR 1-30 DAYS SUPPLY	
Generic Formulary Drug	$20
Brand Formulary Drug	$40
Non-Formulary Drug	$60
FOR 31-90 DAYS SUPPLY	
Generic Formulary Drug	$40
Brand Formulary Drug	$80
Non-Formulary Drug	$120

VISION

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. A list of Participating Providers is available through Customer Service.

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

B. 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 $100 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 Customer Service.

Reimbursement Amount	$100 every two (2) calendar years

GENERAL INFORMATION

ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THE PLAN

Your Group benefits administrator is responsible for maintaining eligibility of Members to receive benefits under the Contract and Handbook and for timely notifying the HMO of such eligibility. The HMO will provide coverage, and terminate coverage, in reliance on the Group's timely notification of the eligibility of Members. If a Group fails to timely notify the HMO of the eligibility status of a particular Member, the HMO will provide and terminate coverage in accordance with any HMO administrative processes.

ELIGIBILITY

Eligible Subscriber

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

A. Who resides or, with approval from the HMO, works in the Service Area; and

B. Who is an active Employee whose normal work week is defined by the Group or is an eligible retiree; and

C. 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

D. For whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling.

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. A 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 the Contract and Handbook, or a child for whom the Subscriber is legally required to provide health care coverage; or

   3. A child for whom the Subscriber or the Subscriber's spouse is a court appointed legal guardian; or

   4. A 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 the Contract and Handbook and for which continuing justification may be required by the HMO; or

   5. A child within the Limiting Age for Dependents under the Contract and Handbook who resides in the Service Area; or

   6. A 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 the 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 the Contract and 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.
9. An adopted child of a Member for the first thirty-one (31) days immediately following (1) birth, if a newborn or, (2) the date of placement for adoption, if not a newborn. Coverage will continue in effect thereafter if the adopted child qualifies as a Dependent, is enrolled by the Subscriber within thirty-one (31) days of birth, if a newborn, or otherwise, the placement date, and any appropriate payment due, calculated from the date of birth or placement, is received by the HMO.

Under the Contract and 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.

EFFECTIVE DATE OF COVERAGE

A. Subject to the receipt of applicable payments from the Group, and of an Enrollment/Change Form from or on behalf of each prospective Member, and subject to the provisions of the Contract and Handbook, including Effective Date of Coverage for special enrollment stated below, coverage for Members under the Contract and Handbook shall become effective on the earliest of the following dates:

   1. When an eligible person makes written application for membership on or prior to the date on which eligibility requirements under this section are satisfied, coverage shall be effective as of the date the eligibility requirements are satisfied; or
   2. When an eligible person makes written application for membership after the date on which the eligibility requirements of this section are satisfied, but within thirty (30) days after becoming eligible, coverage will be effective as of the date the eligibility requirements are satisfied; or

3. Coverage shall become effective at birth for newborn children for thirty-one (31) days. 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, calculated from the date of birth, is received by the HMO; or

4. Coverage for an adopted child shall become effective at birth, if a newborn, and otherwise on the date of placement, for thirty-one (31) days. Coverage will continue in effect thereafter if the adopted child qualifies as a Dependent, is enrolled by the Subscriber within thirty-one (31) days of (a) birth, if a newborn or (b) if not a newborn, the date of placement, and any appropriate payment, calculated from the date of (a) birth, if a newborn or (b) placement, if not a newborn, is received by the HMO; or

5. When an eligible person makes written application for membership during the Group Open Enrollment Period, coverage will begin on the first day of the calendar month following the conclusion of the Group Open Enrollment Period, unless otherwise agreed to by the Group and the HMO.

B. If on the date on which coverage under the Contract and Handbook becomes effective, the Member is receiving Inpatient Care, benefits will be provided under the Contract and Handbook to the extent that such benefits are not provided under a prior group health insurance plan.

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

The eligible employee or a Subscriber's Dependent who was previously eligible for coverage in this HMO program, 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 eligible employee 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. Under a COBRA continuation and the coverage was exhausted; or

2. Under a program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396) (Medicaid) or the state Children's Health Insurance Program established under title XXI of the Social security Act (42 U.S.C. 1397aa) (CHIP) plan and coverage of the employee or dependent under the Medicaid or CHIP plan is terminated as a result of loss of eligibility (e.g., employee receives a raise and now exceeds income requirements) for Medicaid or CHIP coverage; or

3. The employee or dependent becomes eligible for premium assistance from Medicaid or CHIP for their employer's group health plan; or
4. Not under a COBRA continuation, Medicaid, or CHIP, and 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 this HMO program no later than **thirty (30) days** after the date the coverage described in B. 1. or 2. above terminated; or sixty (60) days after the date the coverage described in B. 3. or 4.

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 **thirty (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 **thirty (30) days** of becoming eligible for your new Group's health coverage, you may join this HMO program. 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 this HMO program 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 thirty (30) days of the date during which the individual was first eligible to enroll under this HMO program, you may apply for coverage as a late Subscriber.

Marriage

You may add your spouse to your coverage within thirty (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 a Member but the mother is not a Member, Customer Service must be notified prior to the mother's hospitalization for delivery.

Court-Ordered Dependent Coverage

If 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

Your coverage may be cancelled under the following conditions:

A. If you commit intentional misrepresentation of a material fact or fraud in applying for or obtaining coverage from this HMO program (subject to your rights under the **COMPLAINT 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 **COMPLAINT AND GRIEVANCE APPEAL PROCESS**; or

F. If you do not cooperate with the HMO in obtaining information necessary to determine this HMO program'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 intentional misrepresentation of a material fact, the benefits shall be provided until the earliest of:

A. The expiration of such benefits according to the **SCHEDULE OF COVERED SERVICES** 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 AND GRIEVANCE APPEAL PROCESS.

When a Subscriber's coverage terminates for any reason, coverage of the Subscriber's covered family members will also terminate.

Termination of Coverage at Termination of Employment or Membership in the Group

Coverage for the Member under the Contract and Handbook will terminate on the date specified by the Group if the HMO receives from the Group notice of termination of the Member's coverage within sixty (60) days of the date specified by the Group. If notification from the Group is not received by the HMO within sixty (60) days of the date specified by the Group, the effective date of termination of the Member's coverage shall be sixty (60) days prior to the first day of the month in which the HMO received the notice of termination of the Member's coverage from the Group, with the exception of any services covered under the Inpatient Provision. If the Member is receiving Inpatient Care on the date coverage is terminated, the Inpatient Provision will apply as defined above. Coverage for Dependents ends when the Member's coverage ends.

COVERAGE CONTINUATION

CONTINUATION OF COVERAGE (COBRA)

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Subscriber and his or her Dependents who are covered under this Group Plan on the day before a Qualifying Event may have the right to elect Continuation of Coverage if such coverage would otherwise terminate by reason of a Qualifying Event. This provision for Continuation of Coverage will not apply if the Group ceases to maintain any group HMO for any Employee or if this Group Plan is not obligated under federal law/regulation to provide COBRA coverage/benefits. The Member should contact the Group to find out whether or not these continuation of coverage provisions apply.

Qualifying Events

1. The Subscriber's death;
2. Termination of the Subscriber's employment (except for gross misconduct), or reduction of the Subscribers hours of employment;
3. The Subscriber's divorce or legal separation from his or her spouse;
4. The Subscriber's becoming entitled to benefits under Medicare;

5. The Subscriber's Dependent child ceasing to be a Dependent as defined in this plan; or
6. The substantial elimination of the Subscriber's health coverage during this year or last year due to the Group's filing of a Title XI Bankruptcy, if the Subscriber is a retired covered employee, as defined in the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

The Group shall advise the HMO of the occurrence of the above qualifying events. The Group shall also:

A. Advise Members in writing of their rights to elect and continue to receive COBRA Continuation Coverage;

B. Advise the HMO of the status of each qualified beneficiary electing COBRA Continuation Coverage. The status shall include information on Members whose COBRA coverage should be terminated;

C. Furnish all forms to be used to notify Members as required under the Employee Retirement Income Security Act; and,

D. Fulfill all other administrative and fiduciary responsibilities in connection with the administration of COBRA Continuation Coverage.

For the purposes of this section, coverage for a Dependent child includes coverage for any child born to or placed for adoption with the Subscriber after a Qualifying Event if proper notice is provided to the Group of the birth or adoption.

Continuation must be elected within an election period of sixty (60) days. The sixty (60) day period starts on the later of:

1. The date coverage would otherwise terminate because of a Qualifying Event; or
2. The date the Subscriber is sent notice of the right to elect continuation.

Election of continuation by any qualified Member shall be deemed to include an election of continuation on behalf of any other qualified Member whose coverage under this HMO program would otherwise terminate by reason of the same Qualifying Event. However, if the Subscriber rejects any coverage, his or her Dependents may elect to retain the rejected coverage.

Duration of Continuation of Coverage

If elected, continuation of coverage under this HMO program will continue until the earliest of the following:

1. The date on which continuation ceases because of failure to pay the required premium;
2. The date a Member becomes covered under any other group health plan that:
   A. Does not contain any limitation regarding a pre-existing condition of the beneficiary; or
   B. Does contain a pre-existing exclusion or limitation that would apply to the beneficiary but is not applicable because of the Federal Health Insurance Portability and Accountability Act of 1996 rule on pre-existing condition clauses;

3. The end of 18 months from the date of the Qualifying Event if the event is termination or reduction of the Members employment. However, continuation may be extended an additional eleven (11) months if:

   A. A Member is determined to have been disabled under Titles II or XVI of the Social Security Act at any time during the first sixty (60) days of continuation of coverage;

   B. Notice is furnished to the Group within sixty (60) days of the date of such determination and prior to the end of the 18th month; and

   C. The appropriate additional premium is paid for each month after the 18th month;

4. The first day of the month that begins more than thirty (30) days after the date on which it is determined that the Member is no longer disabled under Titles II or XVI of the Social Security Act if the person's Qualifying Event was termination or reduction of hours of employment and if continuation has been extended beyond 18 months. Notification should be made to the Group within thirty (30) days of any final determination that the Member is no longer disabled under Titles II or XVI of the Social Security Act;

5. The expiration of thirty-six (36) months from the date of the initial Qualifying Event if the initial event or a subsequent Qualifying Event during the continuation period was:

   A. The Subscriber's death;

   B. The Subscriber's divorce or legal separation;

   C. A Dependent child ceasing to be a Dependent as defined in this plan.

   If this expiration date would cause the coverage to terminate on a date other than the last day of a calendar month, coverage will continue until the last day of that month.

6. The date which is no less than thirty-six (36) months after the date the Subscriber becomes covered under Medicare, without regard to whether such event was a Qualifying Event;

7. The date of the Subscriber's death, if the Qualifying Event was the Group's filing of Title XI Bankruptcy; or the death of the Subscriber's spouse, if the Subscriber died before the bankruptcy. Upon the Subscriber's death, his or her Dependent children are entitled to thirty-six (36) months of continuation of coverage;

8. The date on which a person who has elected continuation becomes covered for benefits under Medicare; or

9. The date on which coverage under this plan terminates.

The maximum period for federal continuation of coverage for all qualifying events is thirty-six (36) months after the initial qualifying event, except in certain situations under 7. above.

When the period of continued coverage ends, the Member may have the right to convert his or her coverage. (See **CONVERSION** below.)

CONTINUATION OF COVERAGE PENNSYLVANIA ACT 62 of 2009 (Mini-COBRA)

This subsection, and the requirements of Mini-COBRA continuation, applies to Groups consisting of two (2) to nineteen (19) employees. This provision applies when the Subscriber is an eligible employee of the Group.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify him or her for continuation under this subsection, has been covered continuously for

benefits under this HMO program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:

- The Subscriber;
- The Subscriber's Dependent spouse; or
- The Subscriber's Dependent child.

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

Any person who becomes covered under this HMO program during Mini-COBRA continuation, other than a child born to or placed for adoption with the Subscriber during Mini-COBRA continuation, will not be a qualified beneficiary.

If the Subscriber Terminates Employment or Has a Reduction of Work Hours: If the Subscriber's group benefits end due to his/her termination of employment or reduction of work hours, the Subscriber may be eligible to continue such benefits for up to nine (9) months, if:

1. The Subscriber's termination of employment was not due to gross misconduct;
2. The Subscriber is not eligible for coverage under Medicare;
3. The Subscriber verifies he/she is not eligible for group health benefits as an eligible dependent; and
4. The Subscriber is not eligible for group health benefits with any other carrier.

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

The Group's Responsibilities: The Group must notify the Subscriber, the benefits administrator, and the HMO, in writing, of:

1. The Subscriber's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. The Subscriber's death;
3. The Subscriber's divorce or legal separation from a Dependent spouse covered under this HMO program;
4. The Subscriber becoming eligible for benefits under Social Security;
5. The Subscriber's child ceasing to be a Dependent child pursuant to the terms of this HMO program;
6. Commencement of the Group's bankruptcy proceedings.

The notice must be given to the Subscriber, the benefits administrator and the HMO no later than thirty (30) days of any of these events.

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the benefits administrator or its designee of their election of continuation coverage within thirty (30) days of receipt of the Notice from the Group.

Continuation coverage shall be effective as of the date of the event.

Upon receipt of the Subscriber's, or the Subscriber's covered Dependent's election of continuation coverage, the benefits administrator, or its designee, shall notify the HMO of the election within fourteen (14) days.

If the Subscriber Dies: If the Subscriber dies, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine (9) months, subject to the "When Continuation Ends" paragraph of this subsection.

If the Subscriber's Marriage Ends: If the Subscriber's marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine (9) months, subject to the "When Continuation Ends" paragraph of this subsection.

If a Dependent Loses Eligibility: If the Subscriber's Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this HMO program, other than the Subscriber's 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 nine (9) months, subject to the "When Continued Ends" paragraph of this subsection.

Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the benefits administrator written notice that he or she elects to continue benefits under the coverage. This must be done within thirty (30) days of the date a qualified beneficiary receives notice of his or her continuation rights from the benefits administrator as described above or thirty (30) days of the date the qualified beneficiary's group health benefits end, if later. The Group must notify the HMO of the qualified beneficiary's election of continuation within fourteen (14) days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

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

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

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 HMO program ends on the first to occur of the following:

1. With respect to continuation upon the Subscriber's termination of employment or reduction of work hours, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;
2. With respect to continuation upon the Subscriber's death, the Subscriber's legal divorce or legal separation, or the end of the Subscriber's covered Dependent's eligibility, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;

3. With respect to the Subscriber's Dependent whose continuation is extended due to the Subscriber's entitlement to Medicare, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;
4. The date coverage under this HMO program ends;
5. The end of the period for which the last premium payment is made;
6. 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;
7. The date the Subscriber and/or the Subscriber's eligible dependent become eligible for Medicare.

THE HMO'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER MINI-COBRA ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION.

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

CONVERSION

If 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 Customer 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.

A SUMMARY OF HMO FEATURES

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 Subscriber 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 Subscriber's disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the Subscriber.
   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 this health benefit program, and, subsequently, to all 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.

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** Customer Service if you find an error or lose your ID Card.
- **Carry** your 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.

HMO DESIGN FEATURES

This HMO program is different from traditional health insurance coverage. You will still need to choose a Primary Care Physician to provide routine Medical Care. However, you can access virtually all health care services in the HMO network without a referral. **Referrals are required for X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services.** (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 Handbook.)

It is important to remember the following:

- **Always call your Primary Care Physician before receiving X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services.** Please schedule routine visits well in advance.
- **When you need Specialist Services**, you may go directly to a Participating Specialist for most services without a Referral. **For X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services, you must be Referred by your Primary Care Physician who will give you an electronic or written Referral.**

  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. Your Primary Care Physician must obtain a Preapproval for Specialist Services provided by Non-Participating Providers.

- **Your Primary Care Physician is required to select a Designated Provider for certain Specialist Services.** Your Primary Care Physician will submit an electronic Referral to his/her Designated Provider for these outpatient Specialist Services:

  A. Physical and occupational therapy;

  B. Podiatry services for Members age nineteen (19) and older;

  C. Diagnostic Services for Members age five (5) and older.

  Designated Providers usually receive a set dollar amount per Member per month (capitation) for their services based on the Primary Care Physicians that have selected them.

  Outpatient services are ***not covered*** when performed by any Provider other than your Primary Care Physician's Designated Provider.

  Before selecting your Primary Care Physician, you may want to speak to the Primary Care Physician regarding his/her Designated 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 Customer Service.
- **Some services must be authorized by your Primary Care Physician or Participating Specialist or Preapproved by the HMO.** Your Primary Care Physician or Participating 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. To access a complete list of services that require Preapproval, log onto www.ibx.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. You have the right to appeal any decisions through the **COMPLAINT AND GRIEVANCE APPEAL PROCESS**. Instructions for the appeal will be described in the denial notifications.
- **All services must be received from Participating Providers unless Preapproved by the HMO, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area.**

  See **Access To Primary, Specialist, And Hospital Care** in this section for procedures for obtaining Preapproval for use of a non-Participating Provider. Use your Provider Directory to find out more about the individual Providers, including Hospitals and Primary Care Physicians, Referred Providers and Participating 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 Customer Service 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 this HMO program.** Under this HMO program, Prescription Drugs, including medications and biologicals, are Covered Services or Supplies when ordered during your Inpatient Hospital stay.

  This HMO program provides additional Prescription Drug coverage for Prescription Drugs for use when a Member is not an Inpatient. The benefits and cost sharing will vary depending upon the Prescription Drug addendum program. That coverage may include a Drug Formulary. The Member will be given a copy of the Drug Formulary, and the coverage may exclude, or require the Member to pay higher Copayments for certain Prescription Drugs. To obtain a copy of the Drug Formulary, the Member should call Customer Service at the phone number shown on 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 Customer Service 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 cost sharing through the **COMPLAINT AND GRIEVANCE APPEAL PROCESS** described later in this Handbook.

DISEASE MANAGEMENT AND DECISION SUPPORT

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

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

The 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 Participating Professional Provider's. 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; (3) the Member's Employer decides not to offer the programs.

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 COVERED SERVICES**.

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

See the **Preapproval For Non-Participating Providers** in this section of your Handbook for information regarding services provided by Non-Participating Providers.

ACCESS TO PRIMARY, 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. Care from a participating obstetrical/gynecological Specialist;

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; and

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

NOTE: Referrals from your Primary Care Physician are required for X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services.

HOW TO OBTAIN A PROVIDER REFERRAL

Always consult your Primary Care Physician first when you need X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services.

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

- Your Primary Care Physician will submit an electronic Referral indicating the services authorized.
- Your Referral is valid for ninety (90) days from issue date as long as you are a Member.
- This form is sent electronically to the Referred Provider 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 Provider will require another written Referral from your Primary Care Physician if the recommended treatment is for x-ray, laboratory, podiatry, spinal manipulation or physical/occupational therapy services.
- You must be an enrolled Member at the time you receive services from a Referred Provider 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 Participating Professional Provider to treat that disease or condition. The Referred Provider 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 Customer Service 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 Provider 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 Provider is approved, the Referred Provider, your Primary Care Physician and you will be informed in writing by Care Management and Coordination. The Referred Provider 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 Provider 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 and Coordination and follow the steps outlined above to see if another Standing Referral will be approved.

If the Standing Referral is Denied

If the request for a Standing Referral is denied, 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 PARTICIPATING SPECIALIST AS YOUR PRIMARY CARE PHYSICIAN

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

Follow these steps to initiate your request for your Participating Specialist to be your Primary Care Physician.

A. Call Customer Service 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 Participating Specialist to apprise all parties of the primary services that the Participating 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 Participating 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 Participating Specialist.)

If the Participating Specialist as Primary Care Physician Request is Approved

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

If the Participating Specialist as Primary Care Physician Request is Denied

If the request to have a Participating 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 benefit period. To do so, simply call Customer Service 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 PROVIDER

You may change the Referred Provider 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 Provider before services are performed. Or, you may call Customer Service 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 Provider you regularly visit changes, you will be notified to select another Referred Provider.

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 Customer Service 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 cost-sharing amounts. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

HOSPITAL ADMISSIONS

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

B. Your Primary Care Physician or Participating 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 an electronic Referral from your Primary Care Physician for Inpatient Hospital Services that require Preapproval.

Upon receipt of information from your Primary Care Physician or Participating 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 Participating 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 Participating Specialist to help with your discharge and if necessary, arrange for other medical services.

Should your Primary Care Physician or Participating 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 or Participating Specialist. 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 providers in the HMO network, 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 Handbook (e.g., obtaining Referrals, use of Participating Providers), or to the administration of this Contract by the HMO, the HMO may, on a selective basis, waive certain procedural requirements of the Contract and 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 cost sharing is specified in this Handbook or on the **SCHEDULE OF COVERED SERVICES**, 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.

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.

INFORMATION ABOUT PROVIDER REIMBURSEMENT

The 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 the 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 Customer Service.

Professional Providers

Primary Care Physicians: Most Primary Care Physicians (PCPs) are paid in advance for their services, receiving a set dollar amount per Member, per month for each Member selecting that PCP. This is called a capitation payment and it covers most of the care delivered by the PCP. Covered Services not included under capitation are paid fee-for-service according to the 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 the 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 the 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, Members may want to speak to the PCP regarding the Designated Provider that PCP has chosen.

Hospital-Based Provider: When you receive Covered Services from a Hospital-Based Provider while you are an Inpatient at a Participating Hospital or other Participating Facility Provider and are being treated by a Participating Professional Provider, the Member will receive benefits for the Covered Services provided by the Non-Participating Hospital-Based Provider.

A Hospital-Based Provider can bill the Member directly for their services, for either the Provider's charges or amounts in excess of the HMO's payment to the Hospital-Based Providers (i.e., "balance billing"). If the Member receives any bills from the Provider, the Member needs to contact Customer Services at the telephone number on the ID card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Institutional Providers

Hospitals: For most inpatient medical and surgical Covered Services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete hospital stay related to a specific procedure or diagnosis, (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 the HMO fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory, dental or vision Covered Services, are paid a set dollar amount per Member per month (capitation). Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Mental Health/Substance Abuse

A mental health/Substance Abuse ("behavioral health") management company administers most of the 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.

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 Precertification (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.

Precertification or Preapproval

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

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

While the majority of services requiring Precertification or Preapproval are reviewed for medical appropriateness of the requested procedure setting (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 or Preapproval is not required for Emergency services and is not performed where an agreement with the Participating Provider does not require such review.

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

- hysterectomy
- nasal surgery procedures
- bariatric surgery
- 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 (Precertification or Preapproval) is required, such as maternity admissions/deliveries. Prenotification is primarily used to identify Members for concurrent review needs, to ascertain discharge planning needs proactively, and to identify who may benefit from case management programs.

Discharge Planning

Discharge planning is performed during an inpatient admission and is used to identify and coordinate a Member's needs and benefit plan coverage following the inpatient 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, Precertification, concurrent review, and case management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, neonates/premature infants) or a type of benefit or service (such as behavioral health or radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the 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 Member's.

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

Determination will be made as to whether the Member is also entitled to receive benefits under any other group health care insurance plan or under any governmental program for which any periodic payment is made by or for the Member, with the exception of student accident plans, group hospital indemnity plans paying one hundred dollars ($100) per day or less and, if provided under your plan, coverage for Prescription Drug or vision expenses. If so, the HMO shall determine whether the other insurer or government plan has primary responsibility for payment. In these cases, the payment under the HMO may be reduced or eliminated. The HMO will provide access to Covered Services first and determine liability later.

If it is determined that the HMO is the secondary plan, the HMO has the right to recover the expense already paid in excess of the HMO's liability as the secondary plan. In such cases, only care provided or Referred by the Member's Primary Care Physician will be covered by the HMO as secondary. The Member is required to furnish information and to take such other action as is necessary to assure the rights of the HMO. In determining whether the HMO or another group health plan has primary liability the following will apply.

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. If the other plan does include a Coordination of Benefits or non-duplication provision:

   1. The plan which covers a Member as a Subscriber (meaning not a dependent) will be primary. The plan which covers the Member as a 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. If the other plan does not include this provision, the provisions of that plan will determine the order of benefits.

   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.

   5. Where there is a court decree which establishes financial responsibility for the health care expenses of the child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan.

   6. In cases of joint custody, benefits will be determined by paragraph B.(3) above, the Birthday Rule.

C. The benefits of a plan covering the patient as a laid-off or retired employee or as the Dependent of a laid-off or retired employee shall be determined after the benefits of any other plan covering such person as an employee or dependent of such person. If the other plan does not have the rule regarding laid-off or retired employees, and if, as a result, the plans do not agree on the order of benefits, the rule will be ignored.

D. Where the determination cannot be made in accordance with the preceding paragraphs, the plan which has covered the patient for the longer period of time will be the primary plan.

E. Expenses for the treatment of injury arising out of the maintenance or use of a motor vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:

   1. Under a plan or policy of motor vehicle insurance, provided that non-duplication as contained herein is not prohibited by law; or

   2. Through a program or other arrangement of qualified or certified self-insurance.

F. The HMO may release to or obtain from any person or organization any information about coverage, expenses and benefits, which may be necessary to determine whether the HMO has the primary responsibility of payment. For the purpose of COB, if the Member receives services or supplies available under this Handbook but such is not provided by nor Referred by the Member's Primary Care Physician payment will not be made by the HMO except as provided under this Handbook.

G. Services provided under any governmental program for which any periodic payment is made by or for the Subscriber shall always be the primary plan, except where prohibited by law.

This provision does not apply to an individual health care plan issued to or in the name of the Member.

SUBROGATION

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.

CLAIM PROCEDURES

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

Notice of Claims

The HMO will not be liable for any claims under the Contract and Handbook unless proper notice is furnished to the HMO that Covered Services in the Contract and 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 Customer Service. The telephone number and address of Customer Service can be found on the Member's ID Card. A charge shall be considered Incurred on the date a Member receives the Covered Service for which the charge is made.

Proof of Loss

Claims cannot be paid until a written proof of loss is submitted to the 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 the Contract and 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 Claims 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 the Contract and 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:

A. Person or organization providing the service or supply;

B. Type of service or supply;

C. Date of service or supply;

D. Amount charged; and

E. 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 the Contract and Handbook will be processed immediately upon receipt of proper proof of loss.

COMPLAINT AND GRIEVANCE APPEAL PROCESS

GENERAL INFORMATION ABOUT THE 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 other appeal information in any other way you identify.

  In order to authorize someone to be your Appeal Representative, you must complete valid authorization forms. The required forms are sent to adult Members or to 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.

Information for the Appeal Review:

- **How to File and Get Assistance** - Appeals may be submitted 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 an HMO employee in preparing or presenting your appeal; this assistance will be available at no charge. Please note that the 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.
- **Full and Fair Review** - The Member or designee is entitled to a full and fair review. Specifically, at all appeal levels the Member or designee may submit additional information pertaining to the case, to the HMO. The Member or designee may specify the remedy or corrective action being sought. At the Member's request, the HMO will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The HMO will automatically provide the Member or designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or designee at no charge.
- **Advanced Notice** - The HMO will not terminate or reduce an-ongoing course of treatment without providing the Member or designee with advance notice and the opportunity for advanced review.
- **Urgent Care** - An urgent expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Members with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.
- **Changes in Your Appeals Processes** - Please note that the Members Appeal processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Members Appeals processes, or to reflect other decisions regarding the administration of Members Appeal processes for this HMO program.
- **Appeal Decision Letters -** If the Member's appeal request is not granted in full, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Member may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Member or designee may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.
- **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 by contacting the Pennsylvania Department of Health or the Pennsylvania Insurance Department at:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health and Welfare Bldg.
625 Forster Street
Harrisburg, PA. 17120-0701
Toll Free: 1-888-466-2787
1-717-787-5193
Fax: 1-717-705-0947

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA. 17120
1-877-881-6388
Fax: 1-717-787-8585

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.

A maximum of **forty-eight (48) hours** is available for internal review of an Urgent/Expedited appeal.

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 Customer Service at the telephone number listed on your ID card, or write to:

Manager of Customer Service
Keystone Health Plan East, Inc.
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

You may file a formal Complaint appeal regarding an unresolved dispute or objection regarding coverage, including this HMO program's exclusions and non-Covered Services, coverage Limitations, Participating or Non-Participating Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions), or the operations or management policies of the HMO. The Complaint 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 process in the event your condition involves an urgent issue.

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 Customer Service 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 within **five (5) business days** of receipt of the request.

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.

The First Level Complaint Committee is composed of one (1) HMO employee who has had no previous involvement with your case and who is not subordinate to 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) this HMO program's 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 urgent issue, 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.

Members with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an internal Expedited Complaint Appeal, call Customer Service 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—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.

This HMO program conducts an expedited internal review and issues a decision to you and your practitioner/provider within **forty-eight (48) hours** of the date this HMO program received the appeal. The notification includes the basis for the decision, and the procedure for obtaining an expedited external review.

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 an 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:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health and Welfare Bldg.
625 Forster Street
Harrisburg, PA. 17120-0701
Toll Free: 1-888-466-2787
1-717-787-5193
Fax: 1-717-705-0947

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA. 17120
1-877-881-6388
Fax: 1-717-787-8585

Your request for external review of their 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.

GRIEVANCE APPEAL PROCESS

Formal Member Grievance Appeal Process For Decisions Based On Medical Necessity

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 urgent issue.

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 Customer Service 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 within **five (5) business days** of receipt of the request.

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.

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.

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.

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) this HMO program's 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 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 includes two HMO staff members; at least one of these Committee members is a plan Medical Director, a Physician who holds an active license. Additionally, one third of the Committee is not employed by the HMO.

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 an urgent medical condition, 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.

Members with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an internal Expedited Grievance review by the HMO, call Customer Service 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.

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. Member 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. This HMO program conducts an expedited internal review and issues a decision to the Member and practitioner/provider within **forty-eight (48) hours** of the date this HMO program received the appeal. The notification includes the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

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
P.O. 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 **twenty-four (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.

OTHER COVERAGE

A. Worker's Compensation

Any benefits provided by Worker's Compensation are not duplicated by this HMO program.

B. Medicare

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 this HMO program. For working Members over age 65, the primary payor will be determined in accordance with TEFRA or existing regulations regarding Medicare reimbursement.

NOTE: For more information regarding other coverage, see COORDINATION OF BENEFITS and Subrogation.

INDEPENDENT CORPORATION

The 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 Handbook, or need assistance at any time, please feel free to contact Customer Service by calling the telephone number shown on the ID Card.

IMPORTANT DEFINITIONS

For the purposes of this 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 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 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.

ALLOWED AMOUNT - refers to the basis on which a Member's Deductibles, Coinsurance, Out-of-Pocket Maximum and benefits are calculated.

A. For services provided by a Participating Facility Provider, the term "Allowed Amount" means the lesser of the actual charge and the amount paid by the HMO under a special pricing arrangement with Participating Facility Provider(s) unless the a Participating Facility Provider's contractual arrangement with the HMO provides otherwise.

B. For services provided by a Participating Professional Provider, "Allowed Amount" is the HMO's fee schedule amount.

C. For services provided by Participating Ancillary Providers, "Allowed Amount" means the amount that the HMO has negotiated with the Participating Ancillary Provider as total reimbursement for the Covered Services.

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.

ANNUAL BENEFIT MAXIMUM - the maximum amount of benefits provided to a Member in each benefit period. This amount is shown in the **SCHEDULE OF COVERED SERVICES**. The annual benefit maximum does not include any Copayments, Coinsurance and/or Deductibles paid by the Member.

ANNUAL OUT-OF-POCKET MAXIMUM – the maximum dollar amount that a Member pays for Covered Services under this Handbook in each calendar year as shown in the **SCHEDULE OF COVERED SERVICES**. The Annual Out-of-Pocket Maximum does not include Copayments, Deductibles or any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Handbook.

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. The Away From Home Care Program offers portable HMO coverage to Members traveling in a Host HMO Service Area. Registration for Guest Membership Benefits under the Away From Home Care Program is coordinated by the Away From Home Care Coordinator.

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.

BRAND NAME DRUG - a single source, FDA approved drug manufactured by one company for which there is no FDA approved substitute available.

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 Participating Professional Providers in coordinating Prescribed services, monitor the quality of services delivered, and improve Members outcomes. Case Management supports Members, PCPs and Participating Professional Providers 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 entreostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

CHEMOTHERAPY - the treatment of malignant disease by chemical or biological antineoplastic agents.

COGNITIVE REHABILITATIVE 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 - the percentage of the HMO fee schedule amount which must be paid by the Member (such as 20 percent).

COMPENDIA – one of several tools the HMO will use to determine what services and supplies will be covered by this HMO program. Compendia are prescription drug reference documents that include summaries of how drugs work in the body. These references provide health care professionals with important information about proper dosing and whether a drug is recommended or endorsed for use in treating a specific disease.

Over the years, some compendia have merged with other publications or have discontinued updating their entries. The HMO will access up-to-date compendia to make coverage decisions.

The HMO will review compendia to ensure the most up-to-date drug information and the best available treatment options. This is important because today's ever-expanding industry of drug treatments is dynamic, requiring the constant monitoring and assessment of new interventions.

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 COVERED SERVICES.**

COVERED SERVICE - a service or supply specified in the **DESCRIPTION OF COVERED SERVICES** section of this 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 Participating Professional Provider's treatment plans. Some examples of Decision Support services include support for major treatment decisions and information about everyday health concerns.

DEDUCTIBLE - a specified amount of Covered Services that must be paid by a Member before benefits are provided for any remaining Covered Services. This amount does not include Copayments amounts, any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Handbook.

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 is enrolled under the HMO coverage; and who meets all of the eligibility requirements established by the Group and the HMO as described in the Eligibility section of the **GENERAL INFORMATION** section of this Handbook.

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, 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.

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 Participating Professional Provider, matching interventions to Members with greatest opportunity for improved clinical or functional outcomes. Disease Management programs may employ education, PCP's and Participating Professional Provider 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.

C. It is not of proven benefit for the particular diagnosis or treatment of your particular condition.

D. It 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 your particular condition.

E. It 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 your 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 established Compendia 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/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:

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

FOLLOW-UP CARE – care scheduled for Medically Necessary follow-up visits that occur while the Member is away from home. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is still at home. An example is Dialysis. Follow-Up Care must be Preapproved by the Member's Primary Care Physician prior to traveling. This service is available through the BlueCard Program for temporary absences (less than 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:

A. Certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and

B. 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; school; 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-BASED PROVIDER - A physician who provides Medically Necessary services in a Hospital or other Participating Facility Provider supplemental to the primary care being provided in the Hospital or Participating Facility Provider, for which the Subscriber has limited or no control of the selection of such physician. Hospital-Based Providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by the HMO. When these physicians provide services other than in the Hospital or other Participating Facility, they are not considered Hospital-Based Providers.

HOSPITAL SERVICES - except as limited or excluded herein, acute-care Covered Services furnished by a Hospital, 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.

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.

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.

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 (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.

INTENSIVE OUTPATIENT PROGRAM – planned, structured program comprised of coordinated and integrated multidisciplinary services designed to treat a patient, often in crisis, who suffers from Mental Illness, Serious Mental Illness or Substance Abuse/Substance Abuse Dependency. Intensive Outpatient treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until he or she is able to transition to less intensive outpatient treatment, as required.

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 had 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 COVERED SERVICES**.

LIMITING AGE FOR DEPENDENTS - the age as shown below, at which a Dependent child is no longer eligible as a Dependent under the Subscriber's coverage.

The Limiting Age for Dependents is:

Children under age 26

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 health care.

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) – 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.

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 the Contract and Handbook, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness.

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 Participating Professional Provider.

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.

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

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 X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services.

B. **Referred Provider** – a Participating Provider who provides Covered Services for X-ray, laboratory, podiatry, spinal manipulation and physical/occupational therapy services upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide these services, Referral to a non-Participating Provider will be arranged by your Primary Care Physician with Preapproval by the HMO. See **Preapproval For Non-Participating Providers** for procedures for obtaining Preapproval for use of a non-Participating Provider.

   For the following outpatient services, the Referred Provider is your Primary Care Physician's Designated Provider: (a) Physical and Occupational 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 Covered Services without a Referral. All non-facility obstetrical and gynecological Covered Services are subject to the same Copayment that applies to Office Visits to your PCP.

   Participating obstetricians and gynecologists have the same responsibilities as Participating Specialists. For example, seeking Preapproval for certain services.

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 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.

H. **Participating Specialist** – a Specialist that has contracted with the HMO to provide Covered Services to Members.

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 Participating Professional Provider 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 Participating Professional Provider is required to obtain a Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment. Preapproval is not required for a maternity Inpatient Stay.

To access a complete list of services that require Preapproval, log onto www.ibx.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.

PRENOTIFICATION (PRENOTIFY) - the requirement that a Member provide prior notice to the HMO that proposed services, such as maternity care, are scheduled to be performed. No penalty will be applied for failure to comply with this requirement.

Payment for services depends on whether the Member and the category of service are covered under this plan. To Prenotify, the Member should call the telephone number on the ID card prior to obtaining the proposed service.

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 Customer Service 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 who is certified, registered or who is licensed and performing services within the scope of such licensure. The Professional Providers are:

Audiologist; Certified Registered Nurse; Certified Nurse Midwife; Chiropractor; Dentist; Independent Clinical Laboratory; Licensed Clinical Social Worker (for Mental Health Care and Serious Mental Illness services only); Masters Prepared Therapist; Optometrist; Physical Therapist; Physician; Podiatrist; Psychologist; Registered Dietitian; Speech - language Pathologist; Teacher of the hearing impaired

PROSTHETIC DEVICES - devices (except dental Prosthetics Devices), which replace all or part of:

A. An absent body organ including contiguous tissue; or

B. 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 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** in the **GENERAL INFORMATION** section 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.

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) – 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 Provider. 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, Specialist And Hospital Care** in the **GENERAL INFORMATION** section for procedures for obtaining Preapproval for use of a Non-Participating Provider.

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 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 plan 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.

SELF-INJECTABLE PRESCRIPTION DRUG (SELF-INJECTABLE DRUG) – A Prescription Drug that:

A. Is introduced into a muscle or under the skin by means of a syringe and needle;

B. Can be administered safely and effectively by the patient or caregiver outside of medical supervision regardless of whether initial medical supervision and/or instruction is required; and

C. Is administered by the patient or caregiver.

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.

Benefits are provided for diagnosis and treatment of these conditions when determined to be Medically Necessary and provided by a Behavioral Health/Substance Abuse Provider. A Referral from your Primary Care Physician is not required. Covered Services may be provided on an outpatient or inpatient basis.

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.

SPECIALTY DRUG – A medication that meets certain criteria including, but not limited to:

A. The drug is used in the treatment of a rare, complex, or chronic disease (e.g., hemophilia).

B. A high level of involvement is required by a healthcare provider to administer the drug.

C. Complex storage and/or shipping requirements are necessary to maintain the drug's stability.

D. The drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance.

E. Access to the drug may be limited.

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.

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.

STANDING REFERRAL (STANDING REFERRED) – electronic 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 Provider named in the electronic documentation. The Referred Provider 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 Provider 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 Provider.

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.

IMPORTANT NOTICES

RIGHTS AND RESPONSIBILITIES

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

LANGUAGE AND COVERAGE CHANGES

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.

Unless noted otherwise, the Effective Date of these changes is the later of:

(a) January 1, 2012;

(b) the Contract Date;

(c) the Member's Effective Date of Coverage; or

(d) the Group Master Contract's anniversary date coinciding with or the next following January 1, 2012.

The following changes are made to your **Member Handbook**, unless otherwise noted:

I. The following changes are made for compliance with Federal Law S.2781, known as **Rosa's Law**:

A. All references to "mental retardation" are replaced with "intellectual disability."

II. The following changes are made with regard to **Appeals** and **Eligibility**:

A. With regard to the **Appeals Process,** the Complaint Appeal And Grievance Appeal Process section (or the Complaint and Grievance Appeal Process sub-section of the General Information section) is replaced with the language included in the attached document entitled "Complaint And Grievance Appeal Process."

B. With regard to coverage of **Dependents to Age 26**, the term "Limiting Age for Dependents" under the Important Definitions section is replaced with the following:

LIMITING AGE FOR DEPENDENTS - the age as shown below, at which a Dependent child is no longer eligible as a Dependent under the Subscriber's coverage. A Dependent child shall be removed from the Subscriber's coverage on the first of the month following the month in which your Dependent child reaches the Limiting Age for Dependents.

The Limiting Age for Dependents is 26.

C. With regard to **Termination of Coverage**, the "Termination of Coverage at Termination of Employment or Membership in the Group" provision under the Eligibility, Change, And Termination Rules Under The Plan section (or the Eligibility, Change, And Termination Rules Under The Plan sub-section of the General Information section) is replaced with the following:

Coverage for the Member under this Contract and Handbook will terminate on the date specified by the Group if the HMO receives from the Group notice of termination of the Member's coverage within thirty (30) days of the date specified by the Group. If notification from the Group is not received by the HMO within thirty (30) days of the date specified by the Group, the effective date of termination of the Member's coverage shall be thirty (30) days prior to the first day of the month in which the HMO received the notice of termination of the Member's coverage from the Group, with the exception of any services covered under the Inpatient Provision. If the Member is receiving Inpatient Care on the date coverage is terminated, the

Inpatient Provision will apply as defined above. Coverage for Dependents ends when the Member's coverage ends.

III. The following changes are made with regard to **Durable Medical Equipment** coverage:

A. The provision for Durable Medical Equipment (DME) under the Exclusions-What Is Not Covered section is expanded to include the following items:

- Equipment for safety. Items that are not primarily used for the diagnosis, care or treatment of disease or injury but are primarily utilized to prevent injury or provide a safe surrounding. Examples include: restraints, safety straps, safety enclosures, car seats.

IV. The following changes are made with regard to description of **Reliable Evidence**:

A. The Important Definitions section is revised as follows:

1. The definition of Experimental/Investigative Services is replaced with the following:

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 an on-going Phase III Clinical Trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

C. Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or

E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

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 with a specific indication for the particular diagnosis or condition present. 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 established referenced compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

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

A. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable 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.

2. The definition of Reliable Evidence is replaced with the following:

RELIABLE EVIDENCE – Peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

V. The following changes are made with regard to description of **Genetic Testing and Counseling**:

A. Item D. under Diagnostic Services under the Outpatient Covered Services sub-section (or the Outpatient Services sub-section) of the Description of Covered Services section is replaced with the following:

Genetic testing and counseling, including those services provided to a Member at risk for a specific disease due to family history or because of exposure to environmental factors that are known to cause physical or mental disorders. When clinical usefulness of specific genetic tests has been established by the HMO, these services are covered for the purpose of diagnosis, screening, predicting the course of a disease, judging the response to a therapy, examining risk for a disease, or reproductive decision-making.

VI. The following changes are made with regard to coverage of **Non-Emergency Ambulance** services:

A. The provision "For Non-Emergency Transport" in the Ambulance Services description under the Outpatient Covered Services sub-section (or the Outpatient Services sub-section) of the Description of Covered Services section is replaced with the following:

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 air or ground transport may be covered to return the Member to a Participating Facility Provider within the Member's Service Area for required continuing care (when a Covered Service), when such care immediately follows an Inpatient emergency admission and the Member is not able to return to the Service Area by any other means. Non-emergency transportation back to the Member's Service Area is provided when the Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by either ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance. Transportation back to the Service Area will not be covered for family members or companions.

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

VII. The following changes are made with regard to **Preventive Care and Immunizations**:

A. The Pediatric and Adult Immunizations provision under the Primary and Preventive Care sub-section of the Description of Covered Services section is replaced with the following:

Pediatric and Adult Immunizations

Coverage will be provided for pediatric and adult immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services.

Pediatric and adult immunization ACIP schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/recs/schedules/default.htm.

The benefits for these pediatric immunizations are limited to Members under twenty-one (21) years of age.

B. The term Immunizations under the Important Definitions section is replaced with the following:

IMMUNIZATIONS - Pediatric and adult immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services.

Pediatric and adult immunization ACIP schedules may be found by accessing the following link: http://www.cdc.gov/vaccines/recs/schedules/default.htm.

The benefits for these pediatric immunizations are limited to Members under twenty-one (21) years of age.

VIII. The following changes are made with regard to description of the **Benefit Period**:

1. The Important Definitions section is expanded to include the following:

   BENEFIT PERIOD - the specified period of time as shown in the Schedule of Cost Share and Limitations (or Schedule of Covered Services) during which charges for Covered Services must be Incurred in order to be eligible for payment by the HMO. A charge shall be considered Incurred on the date the service or supply was provided to a Member.

   The Benefit Period is - If your benefit plan is currently based on a Calendar Year, then your Benefit Period is Calendar Year (1/1 – 12/31). If your benefit plan is currently based on a Contract Year, then your Benefit Period is Contract Year (12 month period beginning on group's anniversary date).

2. All references to "Calendar Year" or "Contract Year" throughout the Member Handbook are replaced with "Benefit Period."

3. Your Schedule of Cost Share and Limitations (or Schedule of Covered Services) is revised as follows:

   a. The Schedule is expanded to include the following description for Benefit Period:

      Benefit Period: If your benefit plan is currently based on a Calendar Year, then your Benefit Period is Calendar Year (1/1 – 12/31). If your benefit plan is currently based on a Contract Year, then your Benefit Period is Contract Year (12 month period beginning on group's anniversary date).

   b. All references to "Calendar Year" or "Contract Year" throughout the Schedule are replaced with "Benefit Period."

IX. The following changes are made with regard to **Capitated Laboratory Services**:

A. The paragraph pertaining to "Designated Providers" under the HMO Design Features sub-section of A Summary of HMO Features section (or the HMO Design Features provision under the Summary of HMO Features sub-section of the General Information section) is expanded to include the following additional item in the list of services to be performed by a Designated Provider:

- Laboratory and Pathology Tests

B. The description of Designated Providers under the Professional Providers sub-section of the Information About Provider Reimbursement section (or the Professional Providers provision under the Information About Provider Reimbursement sub-section of the General Information section) is replaced in its entirety with the following:

Designated Providers: For a few specialty services, PCPs are required to select a Designated Provider to which they refer all of the 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, laboratory and pathology tests, 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, Members may want to speak to the PCP regarding the Designated Provider that PCP has chosen.

C. The description of Diagnostic Services under the Outpatient Covered Services sub-section (or the Outpatient Services sub-section) of the Description of Covered Services section is revised to remove the following from the list of services:

Diagnostic laboratory and pathology tests;

D. The Outpatient Covered Services sub-section (or the Outpatient Services sub-section) of the Description of Covered Services section is expanded to include the following:

Laboratory and Pathology Tests

E. The item pertaining to services not provided by a Designated Providers under the Exclusions-What is Not Covered section, is expanded to include the following item:

Laboratory and Pathology Tests

F. The terms listed below under the Important Definitions section are replaced with the following:

1. The definition of Designated Provider is replaced in its entirety with the following:

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; (c) diagnostic radiology services for Members age five (5) or older; or (d) laboratory and pathology tests. The Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

2. The definition of Referred Provider, described under Participating Providers of the Important Definitions section, is revised by replacing the last paragraph with the following:

For the following outpatient services, the Referred Provider 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; (c) certain diagnostic radiology services, if you are age five (5) or older; and (d) laboratory and pathology tests. Your Primary Care Physician will provide a Referral to the Designated Provider for these services.

G. The Schedule of Cost Share and Limitations (or the Schedule of Covered Services) is revised as follows:

1. The sub-section Diagnostic Services is revised to remove the item "Laboratory and Pathology Tests."

2. The Schedule of Cost Share and Limitations (or Schedule of Covered Services) is expanded to include the item "Laboratory and Pathology Tests."

X. The following changes are made with regard to **Utilization Review Process and Medical Policy**:

A. The Important Definitions section is expanded to included the following:

MEDICAL POLICY – Medical Policy is used to determine whether Covered Services are Medically Necessary. Medical Policy is developed based on various

sources including, but not limited to, peer-reviewed scientific literature published in journals and textbooks, guidelines promulgated by governmental agencies and respected professional organizations and recommendations of experts in the relevant medical specialty.

XI. The following changes are made with regard to **Discretionary Language**:

A. The Summary of HMO Features section (or the Summary of HMO Features sub-section of the General Information section) is expanded to included the following:

Discretionary Authority - The HMO retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this plan will be provided only if the HMO determines in its discretion that the Member is entitled to them.

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.

AMENDMENT TO YOUR COMPREHENSIVE MAJOR MEDICAL AGREEMENT

QCC INSURANCE COMPANY

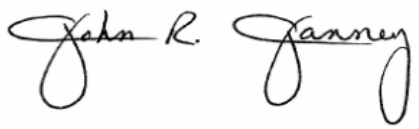
This Notice of Change is issued to form part of your Booklet/Certificate that describes QCC Insurance Company's Comprehensive Major Medical Health Care Program (Form Nos. 16753.BC and 16761.BC).

Effective January 1, 2012, this Notice changes the language that describes the provisions, conditions or other terms of the Booklet/Certificate as detailed below.

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

AMENDMENT TO YOUR COMPREHENSIVE MAJOR MEDICAL AGREEMENT

QCC INSURANCE COMPANY

This Amendment is issued to form part of QCC Insurance Company's Comprehensive Major Medical Program Group Contract (Form No. 00461, 16753 and 16761).

Effective January 1, 2012, this Amendment changes the language that describes the provisions, conditions or other terms of the Group Contract as detailed below.

I. The last item under the subsection Records of Employee Eligibility and Changes in Employee Eligibility of the Contract Provisions section is replaced by the following:

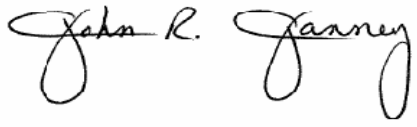
If Contract benefits are provided by and/or approved by the Carrier for Covered Services rendered to a Covered Person before the Carrier receives notice of the Covered Person's termination under the Contract, the cost of such benefits will be the sole responsibility of the Covered Person. The effective date of termination of a Covered Person under the Contract shall not be more than thirty (30) days before the first day of the month in which the Group notified the Carrier of such termination.

II. The Premium Rates subsection of the Contract Provisions section is replaced by the following:

Premium Rates

Premium rates may be changed on the Anniversary Date of the Contract during any year in which the Contract remains in effect, provided that written notice of such proposed change shall be given to the Group by the Carrier on its own behalf not later than thirty (30) days prior to the Anniversary Date of the Contract. Provided, however, that if less than thirty (30) days notice is given by the Carrier, the new premium rate will be effective on the first day of the month following the Anniversary Date. It is also agreed that notice of such change to the Group is notice to those Covered Persons enrolled hereunder, and that payment of the new charges shall constitute acceptance of the change in premium rates.

All other terms of the Group Contract shall remain in effect.



John R. Janney
Sr. Vice President,
Marketing Services

KEYSTONE HEALTH PLAN EAST, INC.
(hereafter called "Keystone" or "the HMO")

1901 Market Street
P.O. Box 7516
Philadelphia, PA 19101-7516

AMENDMENT

This Amendment modifies the Group Master Contract ("the Contract") for certain changes to the plan's Covered Services. Unless noted otherwise, the Effective Date will be the later of January 1, 2012 or:

(a) the Contract Date; or

(b) the Contract's anniversary date coinciding with or next following the effective date of the change.

I. Regarding **TERMINATION OF COVERAGE**, the **"Termination Of Member Coverage By The Group"** under **SECTION GP – GENERAL PROVISIONS**, is replaced with the following:

Coverage for the Member under this Group Contract will terminate on the date specified by the Group if the HMO receives from the Group notice of termination of the Member's coverage within thirty (30) days of the date specified by the Group. If notification from the Group is not received by the HMO within thirty (30) days of the date specified by the Group, the effective date of termination of the Member's coverage under this Group Contract shall be thirty (30) days prior to the first day of the month in which the HMO received the notice of the Member's termination of coverage from the Group, with the exception of any services covered under the Inpatient Provision. If the Member is receiving Inpatient Care on the date coverage is terminated, the Inpatient Provision will apply as described under the **Inpatient Provision upon Termination of Coverage** of the Member Handbook attached to this Contract as listed in **Section BD - Schedule of Benefit Documents**. Coverage for Dependents ends when the Member's coverage ends.

II. The following changes are made with regard to **Discretionary Authority**:

A. Section GP – General Provisions is expanded to include the following:

Discretionary Authority - The HMO retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this plan will be provided only if the HMO determines in its discretion that the Member is entitled to them.

The Group Master Contract is changed only as stated in this Amendment. All provisions of the Group Master Contract not changed by this Amendment still apply.

KEYSTONE HEALTH PLAN EAST, INC.

John R. Janney
Sr. Vice President
Marketing Services

A COMPREHENSIVE MAJOR MEDICAL HEALTH BENEFITS GROUP CONTRACT

By and Between

QCC Insurance Company
(Called "the Carrier")

A Pennsylvania Corporation
Located at
1901 Market Street
Philadelphia, PA 19103

And

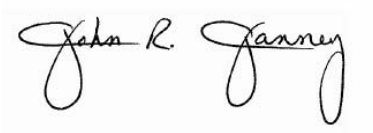
Group Name: **CONTRACTHOLDER NAME**

Group Contract Number(s): **CONTRACT NUMBER(S)**

In consideration of the Group's application for coverage and the payment of premiums when due and subject to all terms of this Comprehensive Major Medical Health Benefits Plan Group Contract (the Contract), the Carrier hereby agrees to provide each eligible Covered Person of the Group and each eligible Covered Person of the Group's subsidiary or affiliated units, if any, under the above Group Number(s), the benefits as described in the Comprehensive Major Medical Health Benefits Plan Booklet/Certificate for eligible persons who enroll hereunder, in accordance with the terms, conditions, limitations, and exclusions of this Contract.

All of the provisions of the booklet/certificate(s) and all modifications made to such booklet/certificate(s), attached to and made a part of the Contract, apply to the Contract as if fully set forth in the Contract.

The Group may accept this Contract by making required payments to the Carrier. Such acceptance renders all terms and provisions hereof binding on the Carrier and the Group.



John R. Janney
SVP Marketing Services

CONTRACT TABLE OF CONTENTS

CONTRACT DEFINITIONS

AMENDMENT - A modification to this Contract or booklet/certificate(s), which changes the original terms of this Contract or Covered Services of the booklet/certificate(s). The changes contained in the Amendment can take the form of one of the following:

A. A statutory Amendment, which reflects a change that has been automatically made to satisfy a requirement(s) of any state law, federal law or regulation that would apply to this Contract, as provided in the "Compliance With Law" subsection of the ***Contract Provisions*** section;

B. A health care Amendment, which reflects a change in the Group's benefits where:

1. The benefits are for services and supplies provided through the Carrier's Providers; and

2. The change applies to all group contracts which include these benefits.

When this Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the health care Amendment;

C. A universal Amendment, which reflects a change in the Carrier's administration of its group benefits and is intended to apply to all group contracts which are affected by the change.

When the Contract is so amended, payment by the Group of the next premium due under this Contract will constitute acceptance of the universal Amendment, unless the Group has rejected the Amendment, in writing, prior to its effective date; or

D. Any combination of the Amendments shown above.

APPLICANT – An employee who applies for coverage under this Contract which the Carrier has entered into with the Group.

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, whether such request was made under a prior carrier's contract which is superseded by this Contract, or under this Contract.

EFFECTIVE DATE – 12:01 A.M. on the date, specified in the Group Application of this Contract, on which coverage under this Contract commences for the Group.

GROUP (CONTRACTHOLDER) – Any entity which employs or represents enrolled employees and, as agent for such enrolled employees, is acceptable to the Carrier and has agreed to remit premium to the Carrier on behalf of enrolled employees and to receive any information from the Carrier on behalf of enrolled employees.

CONTRACT PROVISIONS

A. ENTIRE CONTRACT; CHANGES

1. The entire Contract consists of:

   a. The booklet/certificate(s) attached to this Contract;

   b. Any Amendment made to this Contract or booklet/certificate(s);

   c. Individual applications, if any, of the persons covered; and

   d. The forms shown in ***Contract Table of Contents***, as of the Effective Date of the Contract between the Group and the Carrier.

   No change in this Contract will be effective until approved by an authorized officer of the Carrier. This approval must be noted on or attached to this Contract via an Amendment, signed by an officer of the Carrier. No agent or representative of the Carrier, other than an officer of the Carrier may otherwise change this Contract or waive any of its provisions. All statements made by the Group or by any individual Covered Person shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to claim under this Contract, unless it is contained in a written instrument furnished to the Group or a Covered Person.

2. The Group may not transfer enrollment to another type of Contract issued by the Carrier until the expiration of a period of one (1) year from the Effective Date of this Contract and thereafter from year to year except as otherwise approved by the Carrier.

B. TERMINATION OF THE GROUP CONTRACT

1. The Group may terminate this Contract on any Anniversary Date by giving written notice to the Carrier at least thirty (30) days in advance.

2. This Contract will be terminated for the Group's nonpayment of premium, subject to the "Grace Period" subsection of this ***Contract Provisions*** section.

3. The Carrier reserves the right to terminate this Contract by giving thirty (30) days notice to the Group, in writing, if the Group fails to meet the Carrier's Underwriting Guidelines including, but not limited to, the Group's minimum participation requirements.

4. This Contract will be terminated, at the Carrier's option, for fraud or intentional misrepresentation of a material fact by the Group.

5. The Carrier may, at its option, amend this Contract at least annually. If the Group does not agree to such change(s), the Group must notify the Carrier and the Group may terminate this Contract at the end of the then current contract term.

C. **GRACE PERIOD**

This Contract has a grace period of thirty (30) days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period the Contract will stay in force unless prior to the date payment was due the Group gave timely written notice to the Carrier that the Contract is to be cancelled. If the Group does not make payment during the grace period, the Contract will be cancelled effective on the last day of the grace period and the Carrier will have no liability for services which are Incurred after the Contract's then current paid date. The Group will be required to reimburse the Carrier for all outstanding premiums including the premium for the grace period.

D. **APPLICABLE LAW**

This Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

E. **COMPLIANCE WITH LAW**

If the provisions of the Contract do not conform to the requirements of any state law, federal law or regulation that would be applicable to the Contract, the Contract is automatically changed to comply with the Carrier's interpretation of the requirements of that law or regulation.

F. **NOTICE**

Any notice required under this Contract must be in writing. Notice given to the Group will be sent to the Group's address stated in the ***Group Application***. Notice given to the Carrier will be sent to the Carrier's address stated in the ***Group Application***. Notice given to a Covered Person will be given to the Covered Person in care of the Group or sent to the Covered Person's last address furnished to the Carrier by the Group. The Group, the Carrier, or a Covered Person may, by written notice, indicate a new address for giving notice.

G. **IDENTIFICATION CARDS**

The Carrier will provide Identification Cards to Covered Persons or to the Group, depending on the direction of the Group. Any Identification Card issued by the Carrier in connection with the coverages provided by this Contract, are for identification only. Possession of the Identification Card does not convey any rights to benefits under this Contract. If any Covered Person permits another person to use the Covered Person's Identification Card, the Carrier may revoke that Covered Person's Identification Card.

H. **BENEFIT BOOKLETS/CERTIFICATES**

The Carrier will also provide to each Covered Person of an enrolled Group a benefit booklet/certificate entitled "A Comprehensive Major Medical Health Benefits Plan". It will describe the Covered Person's coverage under the Contract. It will include:

1. To whom the Carrier pays benefits;

2. Any protection or rights when the coverage ends; and

3. Claim rights and requirements.

I. TIMELY FILING

1. The Carrier will not be liable under this Contract 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.

2. 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.

J. RECORDS OF EMPLOYEE ELIGIBILITY AND CHANGES IN EMPLOYEE ELIGIBILITY

1. The Group must furnish the Carrier with any data required by the Carrier for coverage of Covered Persons under this Contract. In addition, the Group must provide written notification to the Carrier within thirty-one (31) days of the effective date of any changes in a Covered Person's coverage status under this Contract.

2. All notification by the Group to the Carrier must be furnished on forms approved by the Carrier. The notification must include all information required by the Carrier to effect changes.

3. Clerical errors or delays in recording or reporting dates will not invalidate coverage which would otherwise be in force or continue coverage which would otherwise terminate.

4. If Contract benefits are provided by and/or approved by the Carrier for Covered Services rendered to a Covered Person before the Carrier receives notice of the Covered Person's termination under the Contract, the cost of such benefits will be the sole responsibility of the Covered Person. The effective date of termination of a Covered Person under the Contract shall not be more than sixty (60) days before the first day of the month in which the Group notified the Carrier of such termination.

K. RELEASE OF INFORMATION

The Carrier may furnish membership and/or coverage information to affiliated plans or other entities for the purpose of claims processing or facilitating patient care.

The Carrier reserves the right to obtain personal health information, medical records, and/or authorizations for care and treatment, in order to establish the Medical Necessity of a treatment, procedure, drug or device for purposes of paying benefits under this Contract.

When the Carrier needs to obtain consent for the release of personal health information, medical records, and/or 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.

L. **TIME LIMIT ON CERTAIN DEFENSES**

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

M. **LIMITATIONS OF THE CARRIER'S LIABILITY**

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

N. **RIGHT TO RECOVER PAYMENTS IN ERROR**

If the Carrier should pay for any contractually excluded services through inadvertence or error, the Carrier maintains the right to seek recovery of such payment from the Provider or Covered Person to whom such payment was made.

O. **RIGHT TO ENFORCE CONTRACT PROVISIONS**

If the Carrier shall choose to waive their rights under this Contract regarding a specific term or provision, it shall not be interpreted as a waiver of their right to otherwise administer or enforce this Contract in strict accordance with the terms and provisions of this Contract.

P. **RELATIONSHIPS AMONG PARTIES AFFECTED BY THE CONTRACT**

1. Neither the Group nor any Covered Person under the Contract is the agent or representative of the Carrier. Neither the Group nor any Covered Person under the Contract will be liable for any acts or omissions:

    a. Of the Carrier, its agents or employees; or

    b. Of any Provider with which the Carrier, its agents or employees make arrangements for furnishing services and supplies to Covered Persons.

2. The choice of a Provider is solely the Covered Person's choice.

Q. **PREMIUM RATES**

Premium rates may be changed on the Anniversary Date of the Contract during any year in which the Contract remains in effect, provided that written notice of such proposed change shall be given to the Group by the Carrier on its own behalf not later than thirty (30) days prior to the Anniversary Date of the Contract. It is also agreed that notice of such change to the Group is notice to those Covered Persons enrolled hereunder, and that payment of the new charges shall constitute acceptance of the change in premium rates.

R. **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 Covered Persons access healthcare services outside the geographic area QCC serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to QCC for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Covered Persons under this contract are described generally below.

Typically, Covered Persons, when accessing care outside the geographic area QCC serves, 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 Covered Persons 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 Covered Persons access covered healthcare services within the geographic area served by a Host Blue, QCC will remain responsible to the Group for fulfilling QCC contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Covered Person liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to QCC by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to QCC by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

1. An actual price. An actual price is a negotiated payment without any other increases or decreases, or

2. An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries,

provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

3. An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to QCC is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either:

1. To use a basis for determining Covered Person liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or

2. To add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, QCC would then calculate Covered Person liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

Determinations of Covered Healthcare Services

If QCC, or if applicable the Group, determine that healthcare services are covered, or the Group medical plan covers the healthcare services, coverage of those healthcare services cannot be denied based on the Host Blue's network protocols. Furthermore, under the BlueCard Program, the Covered Person cannot be denied coverage of healthcare services received outside of the geographic area QCC serves if the healthcare services:

1. Are covered by the network protocols of the Host Blue; and

2. Are not specifically limited or excluded by the group medical plan document.

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.

S. RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

The Group is hereby notified:

This Contract is between the Covered Person or Group, on behalf of itself and Covered Persons, and the Carrier. The Carrier is an independent corporation operating under a license from the 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 the Carrier to use the familiar Blue Cross words and symbols. The Carrier, which is entering into this Contract, is not contracting as an agent of the national Association. Only the Carrier shall be liable to the Covered Person or Group, on behalf of itself and the Covered Persons for any of the Carrier's obligations under this Contract. This paragraph does not add any obligations to this Contract.

SCHEDULE OF BOOKLET/CERTIFICATE(S)

Subject to the exclusions, conditions and limitations set forth in the attached booklet/certificate(s), a Covered Person is entitled to benefits for Covered Services when: (a) deemed Medically Necessary; and (b) billed for by a Provider. Payment allowances for Covered Services are described in the ***Schedule of Benefits*** section of the booklet/certificate(s); and provisions for reimbursement of services provided by Facility Providers and Professional Providers are included under the ***Your Comprehensive Major Medical Benefits Plan*** section.

CONTRACT RATES

Please refer to the "**Confirmation of your new monthly premium rates**" section of your "**Important information about your new group contract**" letter for the Contractholder specific Contract Rates.

GROUP APPLICATION

Application to:

QCC Insurance Company

whose main office address is
1901 Market Street
Philadelphia, PA 19103

By: CONTRACTHOLDER NAME

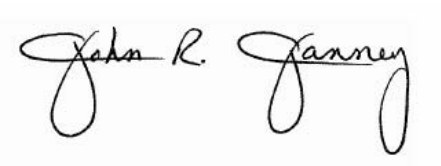
whose main office address is: CONTRACTHOLDER ADDRESS
CITY, STATE ZIP CODE

For Group Contract Number(s): CONTRACT NUMBER(S); with an

Effective Date of: CONTRACT EFFECTIVE DATE; and an Anniversary Date of: CONTRACT ANNIVERSARY; and will renew for a further period of twelve (12) consecutive months and thereafter, from year to year, unless terminated as provided by this Contract; and for the coverage afforded by this Contract, and the terms of which are hereby approved and accepted by the Group to be executed on the Effective Date shown above.

The Application is made to the Contract and it is agreed that this Application supersedes any previous Application for this Contract. The signature below is evidence of QCC Insurance Company's acceptance of the Group Contractholder's Application on the terms hereof, and constitutes execution of this Group Contract attached hereto on behalf of QCC Insurance Company.

QCC INSURANCE COMPANY



John R. Janney
SVP Marketing Services

Comprehensive Major Medical

Health Benefits Program

Self-Referred Benefits

Form No. 16761-BC

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")

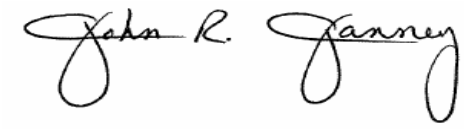
The Carrier certifies that you (the enrolled Employee and your enrolled eligible Dependents, if any) are entitled to the benefits described in this booklet/certificate, subject to the eligibility and effective date requirements.

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

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INTRODUCTION

This booklet/certificate has been prepared so that you (the enrolled Employee and your enrolled eligible Dependents, if any) may become acquainted with 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 Preferred 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 Preferred 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-Preferred 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-Preferred Provider. You can avoid these charges simply by choosing a Preferred 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".

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.

BLUECARD PROGRAM – A program that allows a Covered Person to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard Program.

BLUECARD PROVIDER – A Provider that participates in the BlueCard Program.

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

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

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 Covered Services provided by a Facility Provider, "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Facility or BlueCard Provider, "Covered Expense"
for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or the BlueCard Provider.

ii. For Covered Services provided by a Preferred Facility or BlueCard Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or the BlueCard Provider.

iii. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

iv. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the Medicare Allowable Payment for Facilities. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.

B. For Covered Services provided by a Professional Provider, "Covered Expense" means the following:

i. For Covered Services by a Preferred Professional Provider or BlueCard Provider, “Covered Expense” means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with the Carrier, or the BlueCard Provider.

ii. For a Non-Preferred Professional Provider - “Covered Expense” means the lesser of the Medicare Professional Allowable Payment or of the Provider’s charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier’s applicable proprietary fee schedule or the Provider’s charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier’s applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider’s charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Ancillary Provider or BlueCard Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or BlueCard Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier’s applicable proprietary fee schedule or the Provider’s charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier’s applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Non-Preferred Ancillary Provider’s charges for Covered Services.

D. Nothing in this section shall be construed to mean that the Carrier would provide coverage for services other than 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, 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.

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.

HOSPITAL-BASED PROVIDER - A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which the Covered Person has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by the Carrier. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

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

IMMEDIATE FAMILY - the Covered Person's spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

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

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

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

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

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

MEDICARE ANCILLARY ALLOWABLE PAYMENT – the payment amount, as determined by the Medicare program, for the Covered Service or supply for Ancillary Providers.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT – the payment amount, as determined by the Medicare program, for the Covered Service or supply based on the Medicare Par Physician Fee Schedule – Pennsylvania Locality 01.

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-PREFERRED ANCILLARY PROVIDER - an Ancillary Provider that has not agreed to a rate of reimbursement determined by a contract with the Carrier for the provisions of Covered Services to Covered Persons.

NON-PREFERRED FACILITY PROVIDER - a Facility Provider that has not agreed to a rate of reimbursement determined by a contract with the Carrier for the provisions of Covered Services to Covered Persons.

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

NON-PREFERRED PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider that does not have a contractual relationship with the Carrier for the provisions 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 Ancillary Provider or Facility Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

PARTIAL HOSPITALIZATION 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.

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.

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.

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.

PREFERRED ANCILLARY PROVIDER - an Ancillary Provider that has agreed to a rate of reimbursement determined by a contract with the Carrier for the provisions of Covered Services to Covered Persons.

PREFERRED FACILITY PROVIDER - a Facility Provider that has agreed to a rate of reimbursement determined by a contract with the Carrier for the provisions of Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who has agreed to a rate of reimbursement determined by a contract with the Carrier for the provisions of Covered Services to Covered Persons.

PREFERRED PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider that has agreed to a rate of reimbursement determined by a contract with the Carrier for the provisions of Covered Services to Covered Persons.

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. 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.

REGISTERED DIETITIAN - 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.

SELF-INJECTABLE PRESCRIPTION DRUG (SELF-INJECTABLE DRUG) – A Prescription Drug that: (a) is introduced into a muscle or under the skin by means of a syringe and needle; (b) can be administered safely and effectively by the patient or caregiver outside of medical supervision, regardless of whether initial medical supervision and/or instruction is required; and (c) is administered by the patient or caregiver.

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.

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 (eg, 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.

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, 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.

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 Preferred 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 in the ***Managed Care***. **Failure to obtain precertification will result in a 20% reduction in benefits.**

BENEFIT PERIOD	Please refer to your "**Important information about your new group contract**" letter for the Contractholder specific Benefit Period.
DEDUCTIBLE ***(Covered Person's Responsibility)***	
Covered Person's Deductible	$5,000 per Covered Person per Benefit Period. This Deductible applies to all Covered Services except as otherwise specified in the ***Schedule of Benefits***.
Family Deductible	The family Deductible amount is equal to 3 times the individual Deductible. In each Benefit Period, it will be applied to all family members covered under a Family Coverage. A Deductible will not be applied to any covered individual family member once that covered individual has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.
COINSURANCE ***(Covered Person's Responsibility)***	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.

OUT-OF-POCKET LIMIT	When a Covered Person Incurs $15,000 of Coinsurance expense in one Benefit Period for Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. After 3 times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount. The dollar amounts specified shall not include any expense Incurred for Mental Health/Psychiatric Care, any Deductible, or Copayment amounts.
LIFETIME MAXIMUM	Unlimited per lifetime per Covered Person for Covered Services.
REINSTATEMENT	Amounts applied to a Covered Person's Lifetime Maximum are not restorable.

PRIMARY AND PREVENTIVE CARE	**The Plan pays:**
OFFICE VISITS	50%
PEDIATRIC PREVENTIVE CARE	50% Deductible does not apply.
PEDIATRIC IMMUNIZATIONS	50% Deductible does not apply.
ADULT PREVENTIVE CARE	50% Deductible does not apply.
ROUTINE GYNECOLOGICAL EXAMINATION, PAP SMEAR	50% Deductible does not apply.
MAMMOGRAMS	50% Deductible does not apply.
+ **NUTRITION COUNSELING FOR WEIGHT MANAGEMENT** Maximum of six (6) visits per Benefit Period	50%

INPATIENT BENEFITS	The Plan pays:
HOSPITAL SERVICES Benefit Period Maximum: 70 Inpatient days.	50%
MEDICAL CARE	50%
SKILLED NURSING CARE FACILITY Benefit Period Maximum: 60 Inpatient days.	50%

INPATIENT/OUTPATIENT BENEFITS	The Plan pays:
BLOOD	50%
HOSPICE SERVICES Respite Care: Maximum of 7 days every 6 months.	50%
MATERNITY/OB-GYN/FAMILY SERVICES	
Maternity/Obstetrical Care	
Professional Service	50%
Facility Service	50%
Elective Abortions	
Professional Service	50%
Facility Service	50%
Newborn Care	50%
Artificial Insemination	50%
MENTAL HEALTH/PSYCHIATRIC CARE	
Inpatient Treatment Benefit Period Maximum: 20 Inpatient days.	50%
Outpatient Treatment Benefit Period Maximum: 20 Outpatient visits.	50%
Inpatient Treatment for Serious Mental Illness Benefit Period Maximum: 30 Inpatient days.	50%
Outpatient Treatment for Serious Mental Illness Benefit Period Maximum: 60 Outpatient visits	50%
Each available Inpatient Treatment for Serious Mental Illness day may be exchanged for 2 additional Partial Hospitalization days/Outpatient Treatment sessions.	

INPATIENT/OUTPATIENT BENEFITS…*Continued*	**The Plan pays:**
SURGICAL SERVICES	
Outpatient Facility Charges	50%
Outpatient Professional Charge	50%
Outpatient Anesthesia	50%
Second Surgical Opinion	50%
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.	
TRANSPLANT SERVICES	
Inpatient Facility Charges	50%
Outpatient Facility Charges	50%
TREATMENT OF ALCOHOL OR DRUG ABUSE AND DEPENDENCY	
Inpatient Detoxification	50%
Benefit Period Maximum: 7 days per admission.	
Lifetime Maximum: 4 admissions.	
.....	.....
Inpatient Treatment	50%
Benefit Period Maximum: 30 Inpatient days.	
Lifetime Maximum: 90 Inpatient days.	
.....	.....
Outpatient Treatment	50%
Benefit Period Maximum: 60 Outpatient visits.	
Lifetime Maximum: 120 Outpatient visits.	
30 Outpatient Treatment of Alcohol or Drug Abuse or Dependency days may be exchanged on a 2-to1 basis for 15 additional days of Non-Hospital Residential Care.	

OUTPATIENT BENEFITS	The Plan pays:
AMBULANCE SERVICES Emergency Services Non-Emergency Services	 80% 50%
DAY REHABILITATION PROGRAM Benefit Period Maximum: Thirty (30) sessions.	50%
DIABETIC EDUCATION PROGRAM	50% Deductible and Maximum amounts do not apply.
DIABETIC EQUIPMENT AND SUPPLIES	50%
DIAGNOSTIC SERVICES **Routine Diagnostic/Radiology Services** **Non-Routine Diagnostic/Radiology Services (including, but not limited to MRI/MRA, CT/CTA scans, Nuclear Cardiology Imaging and PET scans)** **Laboratory and Pathology Tests**	 50% 50% 50%
DURABLE MEDICAL EQUIPMENT	50%
EMERGENCY CARE SERVICES	80%

OUTPATIENT BENEFITS *Continued*	**The Plan pays:**
HOME HEALTH CARE	50%
INJECTABLE MEDICATIONS **Specialty Drugs**	50%
Standard Injectable Drugs	50%
MEDICAL FOODS AND NUTRITIONAL FORMULAS	50%
NON-SURGICAL DENTAL SERVICES	50%
ORTHOTICS	50%
PODIATRIC CARE	50%
PRIVATE DUTY NURSING SERVICES Benefit Period Maximum: 360 hours	50%
PROSTHETIC DEVICES	50%
SPECIALIST OFFICE VISITS	50%
SPINAL MANIPULATION SERVICES Benefit Period Maximum: 20 visits	50%

OUTPATIENT BENEFITS ***Continued***	**The Plan pays:**
THERAPY SERVICES	
Cardiac Rehabilitation Therapy Benefit Period Maximum: 36 sessions	50%
Chemotherapy	50%
Dialysis	50%
Infusion Therapy	50%
Orthoptic/Pleoptic Therapy Lifetime Maximum: 8 sessions	50%
Pulmonary Rehabilitation Therapy Benefit Period Maximum: 36 sessions	50%
Physical Therapy/Occupational Therapy Benefit Period Maximum: 30 sessions of Physical Therapy and Occupational Therapy combined Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.	50%
Radiation Therapy	50%
Speech Therapy Benefit Period Maximum: 20 sessions	50%

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 Preferred Providers. The benefits of using these Preferred Providers include:

- **Lower coinsurance payments.** When you use a Preferred 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 Preferred 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.** Preferred Providers agree to accept the amount the Carrier pays, plus your Coinsurance. If you go to a Non-Preferred Provider, the Carrier will pay the applicable percentage as described in the Covered Expense definition in the Defined Terms section. 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 Preferred Provider, you never have to fill out a claim form.

- **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.

A. OUT-OF-NETWORK BENEFITS

The benefits described in this booklet/certificate are the benefits provided when you choose to receive Covered Services without obtaining a referral from your Primary Care Physician or when you choose to receive Covered Services from a Provider that does not belong to the Keystone Network. In both instances, those Covered Services are called “Out-of-Network” services. When you choose Out-of-Network 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 Out-of-Network Care services, when required, may result in a reduction of benefits. You will be financially liable for Penalties assessed for failure to Precertify Out-of-Network services.

B. DEDUCTIBLE

You must Incur a portion of your covered medical expenses before the Carrier begins to pay for benefits. An individual Deductible must be met each Benefit Period before payment will be made for Covered Services. There is also a Family Deductible limit that applies to Family Coverage. In meeting the family Deductible amount, no family member may contribute more than one individual

Deductible amount toward the family Deductible amount. See the ***Schedule of Benefits*** section for the Deductible and Family Deductible amounts 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.

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 ". When the Out-of-Pocket Limit is 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, no family member may contribute more than one individual amount toward this family Out-of-Pocket Limit. See the ***Schedule of Benefits*** for the Out-of-Pocket Coinsurance Limit amounts.

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. 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 Preferred or Non-Preferred Provider.

Preferred 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 Preferred Provider. The Carrier will compensate a Preferred 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. Preferred Providers will, in most instances, submit claim forms for reimbursement on your behalf.

Non-Preferred Providers do not have contractual arrangements for the provision of services to you. When Covered Services and supplies are rendered by these Providers, your Coinsurance costs may be higher, because your Coinsurance is calculated on the lesser of the allowable payment by Medicare, the Carrier's proprietary fee schedule or the Provider's charges. (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.

Emergency Care by Non-Preferred Providers

If the Carrier determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person will be subject to the Preferred cost-sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. For

Emergency Care, the Carrier will reimburse the Covered Person for Covered Services at the Non-Preferred Provider reimbursement rate. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the Defined Terms section of this booklet-certificate. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Carrier. Payment for Emergency Services provided by Non-Preferred Providers will be the greater of: (a) the median of the amounts paid to Preferred Providers for Emergency Services; (b) the amount paid to Non-Preferred Professional Providers; or (c) the amount paid by Medicare.

A Non-Preferred Provider who provided Emergency Care can bill you directly for their services, for either the Provider's charges or amounts in excess of the Carrier's payment for the Emergency Care, i.e., "balance billing." In such situations, you will need to contact the Carrier at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, the Carrier will resolve the balance-billing.

Non-Preferred Hospital-Based Provider Reimbursement

When you receive Covered Services from a Non-Preferred Hospital-Based Provider while you are an Inpatient at a Preferred Hospital or other Preferred Facility Provider and are being treated by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For such Covered Services, payment will be made to the Covered Person, who will be responsible for reimbursing the Non-Preferred Hospital-Based Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Defined Terms section of this booklet-certificate.

A Non-Preferred Hospital–Based Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of the Carrier's payment to the Non-Preferred Hospital-Based Providers, i.e., "balance billing." In such situations, you will need to contact the Carrier at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, the Carrier will resolve the balance billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Hospital Based Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Defined Terms section of this booklet-certificate.

Inpatient Hospital Consultations by a Non-Preferred Professional Provider

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

For such Covered Services, payment will be made to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Professional Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Defined Terms section of this booklet-certificate.

A Non-Preferred Professional Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of the Carrier's payment to the Non-Preferred Professional Providers, i.e., "balance billing." In such situations, you will need to contact the Carrier at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, the Carrier will resolve the balance billing.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider, services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Professional Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the Defined Terms section of this booklet-certificate.

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 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 children 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 Preferred 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.

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 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 Benefit Period, 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 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 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***.

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

G. **Transplant Services**

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

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

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

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

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

H. **Treatment for Alcohol or Drug Abuse and Dependency**

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

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

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:

a. Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification by the appropriately licensed behavioral health provider;
b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
c. Rehabilitation therapy and counseling;
d. Family counseling and intervention;
e. Psychiatric, psychological and medical laboratory testing;
f. Medication management and 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 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 "A. For Emergency Ambulance transport" or "B. For Non-Emergency Ambulance transport".

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

A. For Emergency Ambulance transport:

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

B. For Non-Emergency Ambulance transport:

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 Preferred 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 applicable to Durable Medical Equipment benefits. 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 Medical Equipment benefit subject to the cost-sharing arrangements applicable to Durable Medical Equipment.

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.

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, but not limited to, MRI/MRA, CT/CTA Scans, Nuclear Cardiology Imaging 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.

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

1. It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered “durable”. (For examples, see item d under “Durable Medical Equipment Exclusions” below.)

2. It customarily and primarily serves a medical purpose.

3. It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the Covered Person's illness, injury, or to improvement of a malformed body part.

4. It is appropriate for home use.

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

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

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

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

4. **Non-reusable supplies** other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment. Items not covered include, but are not limited to, incontinence pads, lambs wool pads, ace bandages, 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 repair or replacement of Durable Medical Equipment when the equipment does not function properly and is no longer useful for its intended purpose in the following limited situations:

(a) When a change in the Covered Person's condition requires a change in the Durable Medical Equipment, the Carrier will provide repair or replacement of the equipment.

(b) When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Carrier will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Carrier.

If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of: 1) the Carrier in the case of rented equipment; and, 2) the Covered Person in the case of purchased equipment.

The Carrier will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty, For example, the Carrier will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

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 or defect.

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.

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 treatment of an injury or illness when administered by a Provider.

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 (eg, 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 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.

2. Standard Injectables 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.

J. 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.

K. **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);

L. **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.

M. **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.

N. **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.

O. **Prosthetic Devices**

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

Such expenses may include, but not be limited to:

1. The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and

2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
3. Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive surgery incident and subsequent to mastectomy; and

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 prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Carrier will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

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

P. **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.

Q. **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.

R. **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 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.

5. **Occupational Therapy**

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

6. **Orthoptic/Pleoptic Therapy**

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

7. **Pulmonary Rehabilitation Therapy**

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

8. **Physical Therapy**

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

9. **Radiation Therapy**

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

10. **Speech Therapy**

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

WHAT IS NOT COVERED

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

- Which are not Medically 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;
- 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 podiatric appliances required for the prevention of complications associated with diabetes;

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

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

- For treatment of obesity, except for surgical treatment of 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 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, camp, 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 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 Self-Injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered Self-Injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to Self-Injectable Prescription Drugs that are:

  (a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes; or

  (b) required for treatment of an emergency condition that requires a Self-Injectable Drug.

- For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the ***Description of Benefits***;

- For Inpatient Private Duty Nursing services;

- For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;

- For Maintenance of chronic conditions;

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

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

- For Cognitive 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 of a material fact, the Carrier, may, upon notice to you, terminate the coverage.

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

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

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

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

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

C. TERMINATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP IN THE GROUP

When a Covered Person ceases to be an eligible Employee or eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Plan are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person's termination under this Plan, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under this Plan to be not more than sixty (60) days before the first day of the month in which the Group notified the Carrier of such termination.

D. CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY

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

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

E. CONTINUATION OF INCAPACITATED CHILD

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

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining twenty-six (26) years of age. The disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over twenty-six (26) 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
3. Social Security Administration's determination of disability.

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

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

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

1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your entitlement to Medicare; or
3. 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 legal divorce or legal separation from your spouse, or your Dependent child's loss of eligibility.

The Employer's Liability: Your employer will be liable for the qualified 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,

   a. **After** your termination of employment or reduction of work hours, the end of the thirty-six (36) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
   b. **Before**, your termination of employment or reduction of work hours where, during the eighteen (18) month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the eighteen (18) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than thirty-six (36) months from the date you become entitled to Medicare.

5. The date coverage under this Plan ends;

6 The end of the period for which the last premium payment is made;

7. The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;

8. The date he or she becomes entitled to Medicare.

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

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

G. **WHEN YOU TERMINATE EMPLOYMENT - CONTINUATION OF COVERAGE PROVISIONS PENNSYLVANIA ACT 62 of 2009 (Mini-COBRA)**

This subsection, and the requirements of Mini-COBRA continuation, applies to Groups consisting of two to nineteen employees.

For purposes of this subsection, a “qualified beneficiary” means any person who, before any event which would qualify him or her for continuation under this subsection, has been covered continuously for benefits under this Plan or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination 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 Mini-COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Plan during Mini-COBRA continuation, other than a child born to or placed for adoption with you during Mini-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 eligible to continue such benefits for up to nine (9) months, if:

1. Your termination of employment was not due to gross misconduct;
2. You are not eligible for coverage under Medicare;
3. You verify that you are not eligible for group health benefits as an eligible dependent; and
4. You are not eligible for group health benefits with any other carrier.

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.

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

1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your death;
3. Your divorce or legal separation from an eligible dependent;
4. You becoming eligible for benefits under Social Security;
5. Your dependent child ceasing to be a dependent child pursuant to the terms of the group health benefits booklet-certificate;
6. Commencement of Employer's bankruptcy proceedings.

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

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the administrator or its designee of their election of continuation coverage within thirty (30) days of receipt of the Notice from the Employer.

Continuation coverage shall be effective as of the date of the event.

Upon receipt of your, or your eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the carrier of the election within fourteen (14) days.

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 nine (9) months, subject to the "When Continuation Ends" paragraph of this subsection.

If an Employee's Marriage Ends: If your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine (9) months, 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 nine (9) months, subject to the "When Continued Ends" paragraph of this subsection.

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 thirty (30) days of the date a qualified beneficiary receives notice of his or her continuation rights from the plan administrator as described above or thirty (30) days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Carrier of the qualified beneficiary's election of continuation within fourteen (14) days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the 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 administrative charge of up to five percent of the total premium charge may also be required by the Carrier.

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 nine (9) month period which starts on the date the group health benefits would otherwise end;

2. With respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered Dependent's eligibility, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;
3. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare, the end of the nine (9) month period which starts on the date the group health benefits would otherwise end;

4. The date coverage under this Plan ends;

5. The end of the period for which the last premium payment is made;

6. 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;

7. The date you and/or eligible dependent become eligible for 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.

H. 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.

I. 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.

J. 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.

K. CLAIM FORMS

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

L. 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.

M. 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.

N. 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.

O. 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.

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 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.

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.

Q. SPECIAL CIRCUMSTANCES

In the event that Special Circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for Covered Services under this coverage (e.g., use of Preferred 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 Preferred 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.

MANAGED CARE

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 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 Covered Person'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 Carrier to be Medically Necessary and automatically approved based on the accepted Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by the Carrier based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

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

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

The Carrier's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing physicians with direct access to the Carrier's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Carrier does not specifically reward or provide

financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

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

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

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

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

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

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

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

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

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

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

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

Utilization Review and Criteria for Mental Health/ Substance Abuse Services

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

D. PRECERTIFICATION REVIEW

When required, Precertification review evaluates the Medical Necessity, including the Medical 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. Precertification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a Personal Choice Network Provider. 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 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.

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 Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this ***Managed Care*** section. 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 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 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.

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 Preferred 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 below, 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 Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

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

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

E. OTHER PRECERTIFICATION REQUIREMENTS

Precertification is required by the Carrier in advance for 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.

F. APPEAL PROCEDURE

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

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