PERSONAL CHOICE HEALTH BENEFITS PLAN

A COMPREHENSIVE MAJOR MEDICAL GROUP CONTRACT

By and Between

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

And

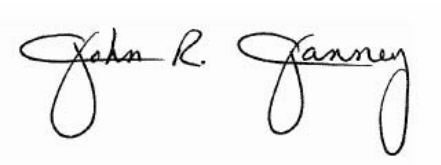
Group Name: **CONTRACTHOLDER NAME**

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 Personal Choice 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 Personal Choice 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

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

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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 "The Personal Choice 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.

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

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. The relationship that exists between the Carrier and any Provider, who is a member of the Carrier's Personal Choice Network, is that of an independent contractor. No Provider, who is a member of the Carrier's Personal Choice Network, is an agent or employee of the Carrier. The Carrier or any employee of the Carrier is not an employee or agent of a Provider, who is a member of the Carrier's Provider Network. Each Provider, who is a member of the Carrier's Personal Choice Network, will maintain the provider-patient relationship with the Covered Persons under the Contract and is solely responsible to Covered Persons for services and supplies furnished to Covered Persons.

2. 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.

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

Q. TERMINATION OF PREFERRED HOSPITAL OR PREFERRED SKILLED NURSING FACILITY CONTRACT

The contract between the Carrier and a Preferred Hospital or a Preferred Skilled Nursing Facility may be terminated, without notice to the Covered Person, in accordance with the provisions thereof, provided however, in the event of such termination, the Preferred Hospital or the Preferred Skilled Nursing Facility shall continue to render services and facilities to such Covered Persons as may be Inpatients at the time of such termination or who are admitted during the ninety (90) day period following the date of such termination.

R. BLUECARD PPO 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.

B. Non-Participating Healthcare Providers Outside the QCC Service Area

Please refer to the "Covered Expense" definition in the ***Important Definitions*** 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.

T. 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. If such proposed change in rates shall not be satisfactory to the Group, the Group shall have the right, by notifying the Carrier in writing not later than thirty (30) days prior to the Anniversary Date of the Contract after receipt by it of the aforesaid notice of such proposed change, to terminate the Contract, and such termination shall become effective as of the Anniversary Date of the Contract following the date of such notification. 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.

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 Covered Services*** section of the booklet/certificate(s); and provisions for reimbursement of services provided by Facility Providers and Professional Providers are included under the ***General Information*** 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

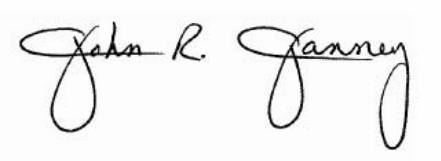
whose main office address is: CONTRACTHOLDER ADDRESS
CITY, STATE ZIP CODE

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

THIS SUPPLEMENTAL MEDICAL-SURGICAL HEALTH CARE CONTRACT FOR NON-PREFERRED SERVICES

effective as of

CONTRACT EFFECTIVE DATE
by and between

CONTRACTHOLDER NAME
(Called the Group)

and

HIGHMARK INC. D/B/A
HIGHMARK BLUE SHIELD*
(Called the Plan)

A Pennsylvania non-profit corporation whose main office is 1800 Center Street, Camp Hill, PA 17089-0089.

This agreement is a Highmark Blue Shield program which supplements the QCC Insurance Company Personal Choice Group contract.

* Independent licensee of the Blue Cross and Blue Shield Association

PBSGR2002
Rev. 5/08

SUPPLEMENTAL MEDICAL-SURGICAL HEALTH CARE CONTRACT
FOR NON-PREFERRED SERVICES

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SECTION GA - GROUP APPLICATION

Application is hereby made

to HIGHMARK INC. D/B/A
HIGHMARK BLUE SHIELD
(Called the Plan)

whose main office address is 1800 Center Street

Camp Hill, Pennsylvania 17089-0089

by CONTRACTHOLDER NAME
(Called the Group)

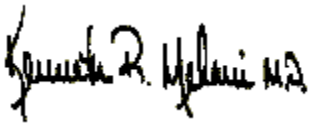
whose main office address is
CONTRACTHOLDER ADDRESS
CITY, STATE ZIP CODE

for the coverage afforded by Group Contract Number CONTRACT NUMBER(S) the terms of which are hereby approved and accepted by the Group.

The Group's Contract Date is CONTRACT EFFECTIVE DATE and the Contract will continue until the following CONTRACT ANNIVERSARY when, unless terminated as provided by this Contract, it will renew for a further period of twelve (12) consecutive months and thereafter, from year to year.

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

HIGHMARK INC. d/b/a
HIGHMARK BLUE SHIELD



Kenneth R. Melani M. D.
Title: President and Chief Executive Officer

SECTION DE - DEFINITIONS

Refer to the definitions within the Personal Choice Group Contract to obtain the meaning of terms which are used within this Contract but are not otherwise defined below.

1. **BENEFIT PERIOD** - the specified period of time, either a Contract Year or a Calendar Year, as shown in the schedule of benefits during which charges for Covered Services must be Incurred in order to be eligible for payment by the Plan. A charge shall be considered Incurred on the date the service or supply was provided to a Subscriber.

2. **CARRIER** - the QCC Insurance Company.

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

4. **CHIROPRACTOR** - a licensed chiropractor performing services within the scope of such licensure.

5. **CLINICAL LABORATORY** - a medical laboratory licensed where required and performing within the scope of such licensure that is not affiliated or associated with a Hospital or Physician.

6. **COINSURANCE** - The percentage of Covered Expenses which must be paid by the Subscriber.

7. **CONTRACT** - the agreement, including the Group Application, riders and/or endorsements if any, between the Plan and the Group, as a supplement to the QCC Insurance Company Personal Choice Group Contract.

8. **CONTRACT DATE** - the date, specified on the Acceptance page of this Contract, on which coverage under this Contract commences for the Group.

9. **COPAYMENT** - a specified amount of expenses applied to a specified Covered Service for which the Subscriber is responsible per covered service.

10. **COVERED SERVICE** - a service or supply specified in this Contract for which benefits will be provided when rendered by a Non-Preferred Professional Provider.

11. **DEDUCTIBLE** - A specified amount of Covered Expenses for the covered services that is incurred by the subscriber before the Plan will assume any liability.

12. **DENTIST** - a licensed doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.).

13. **EFFECTIVE DATE** - according to the Schedule of Eligibility, the date on which coverage for a Subscriber begins under this Contract.

14. **EXPERIMENTAL/INVESTIGATIVE** - the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Plan or its designated agent to be medically effective for the condition being treated.

    The Plan will consider an intervention to be Experimental/Investigative if;

    a. the intervention does not have FDA approval to market for the specific relevant indication(s); or

    b. available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or

    c. the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or

    d. the intervention does not improve health outcomes; or

    e. the intervention is not proven to be applicable outside the research setting.

    If an intervention as defined above is determined to be Experimental/ Investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date.

15. **MEDICALLY NECESSARY AND APPROPRIATE (MEDICAL NECESSITY AND APPROPRIATENESS)** - services or supplies that a Professional Provider, 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.

    The Plan reserves the right, utilizing the criteria set forth in this Definition, to render the final determination as to whether a service or supply is Medically Necessary and Appropriate. No benefits hereunder will be provided unless the Plan determines that the service or supply is Medically Necessary and Appropriate.

16. **NON-PARTICIPATING PROFESSIONAL PROVIDER** - a Professional Provider who has not agreed to accept a rate of reimbursement determined by a contract with the Carrier for the provision of Covered Services to Covered Persons, and who does not have an agreement with Highmark Blue Shield to accept the Plan Payment as payment in full.

17. **NON-PREFERRED PROFESSIONAL PROVIDER** - a Professional Provider who is not a member of the Personal Choice Network.

18. **NURSE-MIDWIFE** - a licensed certified Nurse-Midwife.

19. **OPTOMETRIST** - a licensed Optometrist performing services within the scope of such licensure.

20. **PARTICIPATING PROFESSIONAL PROVIDER** - a Professional Provider who has an agreement with Highmark Blue Shield and who has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

21. **PHYSICAL THERAPIST** - a licensed Physical Therapist. Where there is no licensure law, the Physical Therapist must be certified by the appropriate professional body.

22. **PLAN PAYMENT** - the amount paid by the Plan for which Covered Service or supply is specified in the Contract for which benefits will be provided. This payment means a percentage of Provider's Reasonable Charge.

23. **PODIATRIST** - a licensed Podiatrist performing Services within the scope of such licensure.

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

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

- Audiologist
- Certified Registered Nurse
- Chiropractor
- Clinical Laboratory
- Dentist
- Nurse-Midwife
- Teacher of the Hearing Impaired
- Optometrist
- Physical Therapist
- Physician
- Podiatrist
- Psychologist
- Speech-Language Pathologist

26. **PROVIDER** - a Professional Provider, licensed where required and performing within the scope of their license.

27. **PROVIDER'S REASONABLE CHARGE (PRC)** - For the services of Professional Providers, the Provider's Reasonable Charge will be the Usual, Customary, and Reasonable (UCR) Charge as defined in this Contract or the charge, whichever is lower.

28. **PSYCHOLOGIST** - a licensed Psychologist. When there is no licensure law, the Psychologist must be certified by the appropriate professional body.

29. **SUBSCRIBER** - an enrolled applicant and the applicant's eligible dependents as described in the Personal Choice Group Contract's schedule of eligibility.

30. **USUAL, CUSTOMARY, AND REASONABLE CHARGE** - under the UCR methodology, Highmark Blue Shield determines an allowed amount of Covered Services by applying one or more of the following criteria:

a. USUAL - the allowed amount determined by Blue Shield for a Professional Provider based upon that individual provider's charges for the procedure performed;

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

c. REASONABLE - the allowed amount (which may differ from the Usual or Customary allowed amounts) determined by Blue Shield by considering unusual clinical circumstances.

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

SECTION SE - SCHEDULE OF ELIGIBILITY

Eligibility for coverage under this Contract is specified in the Personal Choice Group Contract that is issued in conjunction with this Supplemental Medical-Surgical Health Care Contract.

SECTION MC - MANAGED HEALTH CARE

Managed Care under this Contract is specified in the Personal Choice Group Contract that is issued in conjunction with this Supplemental Medical-Surgical Health Care Contract.

SECTION SB - SCHEDULE OF BENEFITS

Subject to the Exclusions, Conditions, and Limitations of the Personal Choice Group Contract that is issued in conjunction with this Supplemental Medical-Surgical Health Care Contract, a Subscriber is entitled to benefits for Covered Services under this Contract as listed in the Personal Choice Group Contract's Schedule of Benefits, when rendered by a Participating Professional Provider who is not a Preferred Professional Provider.

SECTION DB - DESCRIPTION OF BENEFITS

Subject to the Exclusions, Conditions, and Limitations of the Personal Choice Group Contract that is issued in conjunction with this Supplemental Medical-Surgical Health Care Contract, a Subscriber is entitled to the benefits for Covered Services under this Contract as described in the Personal Choice Group Contract's Description of Benefits, when rendered by a Participating Professional Provider who is not a Preferred Professional Provider.

SECTION EX - EXCLUSIONS

Exclusions in the Personal Choice Group Contract that is issued in conjunction with this Supplemental Medical-Surgical Health Care Contract, are applicable.

SECTION GP - GENERAL PROVISIONS

A. ENTIRE CONTRACT; CHANGES

This Contract with the Group Application, the individual applications, if any, of the Employees, and the Amendatory Riders and/or Schedules in conjunction with the Personal Choice Group Contract is the entire Contract between the Group and the Plan. No change in this Contract will be effective until approved by an authorized Plan officer. This approval must be noted on or attached to this Contract. No agent or representative of the Plan other than a Plan officer may otherwise change this Contract or waive any of its provisions. All statements made by the Group or by any individual Subscriber shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Contract, unless it is contained in a written application.

B. BENEFITS TO WHICH SUBSCRIBERS ARE ENTITLED

1. The liability of the Plan is limited to the benefits specified in the Personal Choice Group Contract.

2. Except as provided in the Managed Care Contract in respect to Human Organ and Tissue Transplant, no person other than a Subscriber is entitled to receive benefits under this contract. Such right to benefits and coverage is not transferable except in the case of a custodial parent of a Dependent covered under this contract as required by law.

3. Benefits for Covered Services specified in this Contract will be provided only for services and supplies that are rendered by a Provider specified in the Definitions section of this Contract and regularly included in such Provider's charges.

C. RECORDS OF SUBSCRIBER ELIGIBILITY AND CHANGES IN SUBSCRIBER ELIGIBILITY

1. The Group must furnish the Plan with any data required by the Plan for coverage of Subscribers under this Contract. In addition, the Group must provide prompt notification to the Plan of the effective date of any changes in a Subscriber's coverage status under this Contract.

2. All notification by the Group to the Plan must be furnished on forms approved by the Plan. The notification must include all information reasonably required by the Plan 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. Upon discovery of errors or delays, an equitable adjustment of charges and benefits will be made.

4. The Group is liable for the cost of all Contract benefits which are provided for services rendered to a terminated Subscriber because of the Group's failure to notify the Plan of such Subscriber's termination on or before the termination date.

D. **TERMINATION OF THE GROUP CONTRACT; GRACE PERIOD**

1. Either the Group or the Plan may cancel this Contract on any Contract anniversary by giving written notice to the other party at least thirty (30) days in advance. This Contract will terminate automatically upon termination of the Personal Choice Group Contract.

2. See Personal Choice Group Contract for additional provisions.

E. **TERMINATION OF THE SUBSCRIBER'S COVERAGE**

1. When a Subscriber ceases to be an eligible Subscriber under the Personal Choice Group Contract and therefore ineligible under this Contract, the Subscribers coverage will terminate at the end of the month in which the Subscriber became ineligible.

2. The Subscriber's coverage under this Contract shall terminate:

   (a) on the first day of the month following the receipt of the Subscriber's written termination request.

   (b) upon thirty (30) days written notice of termination for cause (such as fraudulent use of an Identification Card) by the Plan. However, the Plan will not terminate coverage because of a Subscriber's Medically Necessary and Appropriate utilization of Covered Services;

   (c) if the Subscriber, in obtaining coverage hereunder, is guilty of fraud or material misrepresentation of fact. In such case, the Plan may, at its option, treat the Subscriber's coverage as canceled. The Subscriber will forfeit any charges paid to the extent of the liability incurred by the Plan.

   (d) if the Subscriber knowingly permits abuse or misuse of the Subscriber identification Card; or

   (e) at 12:01 a.m. on the termination date reflected on the records of the Plan; or

   (f) when the Group Contract terminates.

F. **NOTICE OF CLAIM**

1. The Plan will not be liable under this Contract unless proper notice is furnished to the Plan that Covered Services have been rendered to a Subscriber. Written notice must be given within 90 days after completion of the Covered Services. The notice must include the data necessary for the Plan to determine benefits. A charge shall be considered Incurred on the date a Subscriber receives the service or supply for which the charge is made.

2. Failure to give notice to the Plan 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 Plan be required to accept notice more than 24 months after the charge for Covered Services was Incurred.

G. RELEASE OF INFORMATION

Each Subscriber agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Contract may furnish it to the Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, the Plan may furnish similar information regarding claims and charges submitted to the Plan by Hospitals, Facility Other Providers, Professional Providers or Professional Other Providers. The Parties understand that any information provided to the Group may be adjusted by the Plan to prevent the disclosure of the identity of any Subscriber or other patient treated by said Providers. The Group shall reimburse the Plan for the actual costs of preparing and providing said information. The Plan shall provide the Group with such expense prior to incurring such costs.

H. LIMITATION OF ACTIONS

See Personal Choice Group Contract.

I. PAYMENT OF BENEFITS

1. The Plan is authorized by the Subscriber to make payments directly to Providers (or Suppliers) furnishing Covered Services for which benefits are provided under this Contract. However, the Plan reserves the right to make the payments directly to the Subscriber. As required by law, the right of a Subscriber to receive payment is not assignable nor may benefits of this Contract be transferred, either before or after covered services are rendered.

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

J. SUBSCRIBER/PROVIDER RELATIONSHIP

1. The choice of a Provider is solely the Subscriber's.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Subscribers. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Subscriber.

3. The use or non-use of an adjective such as Participating, or Non-Participating in modifying any Provider is not a statement as to the ability of the Provider.

K. AGENCY RELATIONSHIP

The Group is the agent of the Subscribers, not the Plan.

L. PARTICIPATING PLAN

The Plan may make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Subscribers.

Wherever Plan is used in this Contract, it includes Participating Plan(s) unless the context clearly indicates to the contrary.

M. **APPLICABLE LAW**

This Contract is entered into and is subject to the laws of the Commonwealth of Pennsylvania.

N. **SUBSCRIBER RIGHTS**

A Subscriber shall have no rights or privileges as to the benefits provided under this Contract as a supplement to the Personal Choice Group Contract except as specifically provided herein.

O. **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 Plan will be sent to the Plans address stated in the Group Application. Notice given to a Subscriber will be sent to the Subscribers address as it appears on the records of the Plan or in care of the Group. The Group, the Plan, or a Subscriber, may, by written notice, indicate a new address for giving notice.

P. **COORDINATION OF BENEFITS**

See Personal Choice Group Contract.

Q. **SUBROGATION**

See Personal Choice Group contract.

R. **BENEFITS AFTER TERMINATION OF COVERAGE**

See Personal Choice Group contract.

S. **PROVIDER REIMBURSEMENT**

Reimbursement of Professional Providers

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

b. Participating and Non-Participating Professional Provider Reimbursement

Benefit amounts, as specified in the Personal Choice Group Contract, refer to Covered Services rendered by a Participating Professional Provider which are regularly included in such Professional Provider's charges and are billed by and payable to such Professional Provider. Participating Professional Provider payment will be made in accordance with the Plan Payment.

When Covered Services are performed by a Non-Participating Professional Provider, the Plan reserves the right to make payment to the Subscriber. Plan Payment for Covered Services rendered by a Non-Participating Provider are calculated in accordance with the Personal

Choice Group Contract. Any difference between the Non-Participating Professional Providers charge and the Plan Payment shall be the personal responsibility of the Subscriber.

c. Except as required by law, the right of a Subscriber to receive payment is not assignable nor may benefits of this Contract be transferred, either before or after Covered Services are rendered.

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

e. Service Benefits Provision

Service Benefits apply to Subscribers who utilize Participating Professional Providers. Participating Professional Providers have agreed to accept the Provider's Reasonable Charge as payment in full for Covered Services. Participating Professional Providers will make no additional charge for service benefits to Subscribers for Covered Services except in the case of certain Deductibles, Coinsurances, Co-payments, or amounts exceeding Maximums referred to in this Contract and/or the Personal Choice Group Contract. If payment is not made within 60 days, the participating professional provider may bill the subscriber the difference between the charge and PRC.

Any dispute between the Participating Professional Provider and a Subscriber with respect to balance billing shall be submitted to the Plan for determination. The decision by the Plan shall be final.

T. CONFIDENTIALITY

The records of the Plan developed and maintained in conjunction with providing payments of benefits under the terms of this Contract are proprietary and confidential to the Plan. To the extent that the Group requires such information, the Group shall in every case comply with the procedures of the Plan for obtaining such information and hold such information in the strictest confidence.

U. COMPLIANCE WITH LAW; AMENDMENT

Anything contained herein to the contrary notwithstanding, the Plan shall have the right, for the purpose of complying with the provisions of any law or lawful order of a regulatory authority, to amend this Contract, including any Amendatory Riders hereto, or to increase, reduce or eliminate any of the benefits provided for in this Contract for any one or more eligible Subscribers enrolled under this Contract, and each party hereby agrees to any amendment of this Contract which is necessary in order to accomplish such purpose. Should the change to this Contract, to comply with the law, have a material financial impact on the payment of benefits pursuant to this Contract, the parties shall cooperate and negotiate in good faith to determine an equitable amendment to the financial terms of this Contract. Provided, however, that the failure of the parties to so agree on the amendment to the financial terms of this Contract within 30 days after notice of the amendment has been received shall entitle either party to thereupon terminate this Contract, such termination to be effective no less than 30 days after written notice of termination has been received by the non-terminating party.

V. **RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS**

This contract is between the Group, on behalf of itself and the Subscribers and Highmark Blue Shield only. Highmark Blue Shield 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 Highmark Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols. Highmark Blue Shield shall be liable to the Group, on behalf of itself and the Subscribers for any of the Plans obligations under this Contract. This paragraph does not add any obligations to this Contract.

sup/rev.5/08

AMENDMENT TO YOUR PERSONAL CHOICE/PPO AGREEMENT

QCC INSURANCE COMPANY

This Amendment is issued to form part of QCC Insurance Company's Personal Choice/PPO Health Benefits Program Group Contract (Form No. 16750).

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:

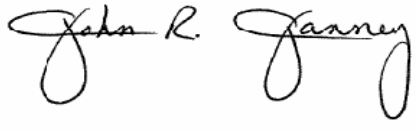
If Contract benefits are provided by and/or approved by the Carrier for Covered Services rendered to a Covered Person before the Carrier receives notice of the Covered Person's termination under the Contract, the cost of such benefits will be the sole responsibility of the Covered Person. The effective 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

PERSONAL CHOICE HEALTH BENEFITS PLAN

A COMPREHENSIVE MAJOR MEDICAL GROUP BOOKLET-CERTIFICATE

By and Between

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

And

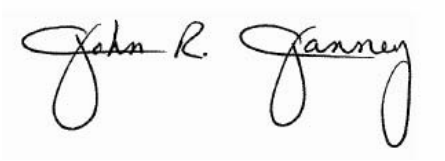
Group (Contractholder)
(Called "the Group")

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:



John R. Janney
SVP Marketing Services

Comprehensive Major Medical Coverage that utilizes a Preferred Provider Network to maximize benefits while offering Covered Persons the choice of selecting Non-Preferred Providers, except where specifically prohibited by the contract, subject to a reduction of benefits. This coverage utilizes extensive Precertification and utilization management procedures, which must be followed to maximize benefits and avoid penalties. Failure to obtain Precertification for services provided by a BlueCard PPO Provider or an Out-of-Network Provider will result in a twenty percent (20%) reduction in benefits.

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INTRODUCTION

Thank you for joining QCC Insurance Company (the Carrier). Our goal is to provide you with access to quality health care coverage. This Booklet/Certificate 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 Carrier are described in the ***Description of Covered Services*** section of this Booklet/Certificate. Benefits, exclusions and limitations appear in the ***Exclusions – What Is Not Covered*** and the ***Schedule of Covered Services*** sections of this Booklet/Certificate.

Please remember that this Booklet/Certificate is a summary of the provisions and benefits provided in the program selected by your Group. Additional information is contained in the Group Contract available through your Group benefits administrator. The information in this Booklet/Certificate is subject to the provisions of the Group Contract. If changes are made to your Group's Plan, you will be notified by your Group benefits administrator. Group 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 Contract anniversary date coinciding with or next following that service's effective date.

Please read your Booklet/Certificate thoroughly and keep it handy. It will answer most of your questions regarding the Carrier's procedures and services. **If you have any other questions, call the Carrier's Customer Service Department ("Customer Service") at the telephone number shown on your ID Card.**

Any rights of a Covered Person to receive benefits under the Group Contract and Booklet/Certificate are personal to the Covered Person 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 Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the Group Contract and Booklet/Certificate, as required by law.

See ***Important Notices*** section for updated language and coverage changes that may effect this Booklet/Certificate.

DESCRIPTION OF COVERED SERVICES

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 Covered Services*** 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 Covered Services***.

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

Some Covered Services must be Precertified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the ***General Information*** 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 other cost-sharing requirements are specified in the ***Schedule of Covered Services***.

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

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

Office Visits

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

Pediatric Preventive Care

Pediatric Preventive Care includes the following:

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

Twenty-six (26) examinations up to age seventeen (17) – according to each of the following age groupings:

- Eleven (11) exams between the ages of 0-30 months within the following age ranges:

3-5 days	12-14 months
0-1 month	15-17 months
2-3 months	18-23 months
4-5 months	24-29 months
6-8 months	30 months
9-11 months	

- One (1) exam every Benefit Period between three (3) and seventeen (17) years of age

B. **Blood Lead Screening**. This blood test detects elevated lead levels in the blood. Children are covered for:

- One (1) test between 9-12 months of age
- One (1) test at twenty-four (24) months of age

C. **Hemoglobin/Hematocrit**. This blood test measures the size, shape, number and content of red blood cells. Children are covered for:

- One (1) test between 0-12 months of age
- One (1) test between one (1) and four (4) years of age
- One (1) test between five (5) and twelve (12) years of age
- One (1) test between thirteen (13) and seventeen (17) years of age

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

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

- One (1) test every 365 days between 0-24 months of age
- One (1) test every Benefit Period between two (2) and seventeen (17) years of age

Pediatric Immunizations

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Benefits are limited to Covered Persons under twenty-one (21) years of age.

Adult Preventive Care

A. **Physical Examination, Routine History**. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons eighteen (18) years of age or older in accordance with the following schedule:

- One (1) examination every Benefit Period at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
- One (1) examination every two (2) Benefit Periods between twenty-two (22) and thirty-nine (39) years of age
- One (1) examination every Benefit Period, beginning at forty (40) years of age

B. **Adult Tetanus Toxoid (TD).** This immunization provides immunity against tetanus and diphtheria.

- One (1) test every ten (10) Benefit Periods, beginning at eighteen (18) years of age

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

- One (1) test every four (4) Benefit Periods between eighteen (18) and thirty-nine (39) years of age
- One (1) examination every Benefit Period, beginning at forty (40) years of age

D. **Complete Blood Count (CBC).** This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.

- One (1) test every Benefit Period at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
- One (1) examination every two (2) Benefit Periods between twenty-two (22) and thirty-nine (39) years of age
- One (1) test every Benefit Period, beginning at forty (40) years of age

E. **Fecal Occult Blood Test.** This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.

- One (1) test every Benefit Period, beginning at fifty (50) years of age

F. **Flexible Sigmoidoscopy.** This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.

- One (1) test every three (3) Benefit Periods, beginning at fifty (50) years of age

G. **Influenza Vaccine.** This vaccine provides immunization against influenza type A and B viruses.

- One (1) vaccine every Benefit Period, beginning at eighteen (18) years of age

H. **Pneumococcal Vaccine.** This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.

- One (1) vaccine every five (5) Benefit Periods, beginning at sixty-four (64) years of age

I. **Prostate Specific Antigen (PSA).** This blood test may be used to detect tumors of the prostate.

- One (1) test every Benefit Period, beginning at fifty (50) years of age

J. **Routine Colonoscopy.** This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.

- One (1) test every ten (10) Benefit Periods, beginning at fifty (50) years of age

K. **Rubella Titer Test.** The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the adult has ever been immunized.

- One (1) test and immunization between eighteen (18) and forty-nine (49) years of age

L. **Thyroid Function Test.** This test detects hyperthyroidism and hypothyroidism.

- One (1) series of tests every Benefit Period, beginning at eighteen (18) years of age

M. **Urinalysis.** This test detects numerous abnormalities.

- One (1) test every Benefit Period, beginning at eighteen (18) years of age

N. **Varicella Vaccine.** This vaccine is recommended for women of childbearing age who have not been previously exposed to the chicken pox virus.

- One (1) immunization for women between eighteen (18) and forty-nine (49) years of age

O. **Fasting Blood Glucose Test.** This test is used for detection of diabetes

- One (1) test every three (3) years, beginning at age forty-five (45).

P. **Abdominal Aortic Aneurysm screening.** One (1) test per lifetime is recommended for men with a smoking history.

- One (1) ultrasound for men between sixty-five (65) and seventy-five (75) years of age.

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

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.

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.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

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

- One screening test every two (2) Benefit Periods beginning at age 65

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 Covered Services***.

INPATIENT SERVICES

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 other cost-sharing requirements are specified in the ***Schedule of Covered Services***.

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 the Covered Person's condition;
2. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
3. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
4. Oxygen and oxygen therapy;
5. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
6. 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;
7. 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;
8. Use of special care units, including, but not limited to, intensive or coronary care; 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 Carrier 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.

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

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.

Medical Care

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

A. **Concurrent Care**

Services 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.

B. **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.

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 Covered Services***. 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 or her 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 Covered Services***.

No Skilled Nursing Care Facility benefits are payable:

A. 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;
B. For the treatment of Alcohol and Drug Abuse or dependency, and mental illness; or
C. 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 SERVICES

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 other cost-sharing requirements are specified in the ***Schedule of Covered Services***.

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 or her 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.

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:

A. Services and supplies for which there is no charge;
B. Research studies directed to life lengthening methods of treatment;
C. 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);
D. Care provided by family members, relatives, and friends; and
E. Private Duty Nursing care.

Maternity/OB-GYN/Family Services

A. **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 Covered Services***. Prenotification of maternity care should occur within one (1) month of the first prenatal visit to the Physician or midwife. Benefits are payable for: (a) facility services provided by a Hospital or Birth Center; and (b) 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 ***General Information*** 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.

B. **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.

C. **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 ***General Information*** section.

D. **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.

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

A. **Inpatient Treatment**

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

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

B. **Outpatient Treatment**

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

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

C. **Benefits are not payable for the following services:**

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

D. **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 Covered Services***. Non-Preferred Benefit Period maximums are part of, not separate from, Preferred Benefit Period maximums.

Routine Costs Associated With Qualifying Clinical Trials

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

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: (a) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (b) 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: (a) 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 (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedemas is not subject to any benefit Maximum amounts that may apply to "Physical Therapy" services as provided under the subsection entitled "Therapy Services" of this section.

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

A. **Hospital Admission for Dental Procedures or Dental Surgery**

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such

a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Plan will be covered during such a confinement.

B. **Oral Surgery**

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

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. Benefits will be provided only for:

   a. Surgical removal of impacted teeth which are partially or completely covered by bone;

   b. The 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.

C. **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.

D. **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).

E. **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.

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:

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

B. 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.

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

D. 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.

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 Covered Services***, according to the provisions outlined below. For maximum benefits, treatment must be received from a Preferred Provider.

A. **Inpatient Treatment**

1. **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:

a. Lodging and dietary services;
b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
c. Diagnostic x-rays;
d. Psychiatric, psychological and medical laboratory testing;
e. Drugs, medicines, use of equipment and supplies.

2. **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 Covered Services***.

Covered services include:

a. Lodging and dietary services;
b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
c. Rehabilitation therapy and counseling;
d. Family counseling and intervention;
e. Psychiatric, psychological and medical laboratory testing;
f. Drugs, medicines, use of equipment and supplies.

B. **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 Covered Services***.

Covered services include:

1. Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification by the appropriately licensed behavioral health provider;
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. Medication management and use of equipment and supplies.

OUTPATIENT SERVICES

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 other cost-sharing requirements are specified in the ***Schedule of Covered Services***.

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:

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.

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

Day Rehabilitation Program

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

A. 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;

B. 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;

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

D. 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.

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: (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 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:

A. Initial assessment of the Covered Person's needs;
B. Family involvement and/or social support;

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

Diabetic Equipment and Supplies

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance to Durable Medical Equipment benefits, for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. If this Plan provides benefits for prescription drugs (other than coverage for insulin and oral agents only), 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.

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.

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

Diagnostic Services

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, 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 ECG, EEG, and other diagnostic medical procedures approved by the Carrier), and allergy testing (consisting of percutaneous, intracutaneous and patch tests).

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

C. Diagnostic laboratory and pathology tests.

D. 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.

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 ***Important Definitions*** section, includes equipment that meets the following criteria:

A. 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.)
B. It customarily and primarily serves a medical purpose.
C. 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.
D. 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:

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

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

C. **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.

D. **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.

E. **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.

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

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

H. **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.

I. **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:

(1) 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.

(2) 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.

Emergency Care Services

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

Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency.

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.

Home Health Care

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

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.

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: (1) it would involve a considerable and taxing effort by the Covered Person; and (2) 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 (1) and (2).

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:

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. Services provided by a member of the Covered Person's Immediate Family;
F. Covered Person's transportation, including services provided by voluntary ambulance associations for which the Covered Person 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 Covered Person 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 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.

Injectable Medications

Benefits will be provided for injectable medications required in the treatment of an injury or illness when administered by a Provider.

A. **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 to www.ibxpress.com or call the Customer Service telephone number listed on the back of your Identification Card. The purchase of all Specialty Drugs is subject to Coinsurance. The Coinsurance amounts are shown in the ***Schedule of Covered Services***. Coinsurance amounts will apply: (1) to each thirty (30) day supply of medication dispensed for medications administered on a regularly scheduled basis; or (2) 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.

B. **Standard Injectable Drugs**

1. 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;

2. Self-Injectable Drugs generally are not covered. For more information on Self-Injectable Prescription Drugs (Self-Injectable Drugs), please refer to the ***Exclusions - What Is Not Covered*** section and the description of Insulin and Oral Agents coverage in the ***Description of Covered Services*** section.

Insulin and Oral Agents

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

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) 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 (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 Durable Medical Equipment supplier or in connection with Infusion Therapy as provided for in this plan.

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 ***Exclusions - What Is Not Covered*** section for more information on what dental services are not covered).

Orthotics

Benefits are provided for:

A. 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.

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

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.

Private Duty Nursing Services

Benefits will be provided up to the number of hours specified in the ***Schedule of Covered Services*** 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:

A. Nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;
B. Services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family; and
C. Services provided by a home health aide or a nurse's aide.

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:
A. 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
B. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;
C. 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;
D. Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
    1. Initial contact lenses prescribed for treatment of infantile glaucoma;
    2. Initial pinhole glasses prescribed for use after surgery for detached retina;

3. Initial corneal or scleral lenses prescribed: (a) in connection with the treatment of keratoconus; or (b) 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. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of: (a) Accidental Injury; (b) trauma; or (c) ocular surgery.

Benefits are not provided for:
1. Lenses which do not require a prescription;
2. 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;
3. Deluxe frames; or
4. Eyeglass accessories, such as cases, cleaning solution and equipment.

The repair and replacement provisions do not apply to this item D.

Benefits for replacement of a Prosthetic Device or its parts will be provided: (1) when there has been a significant change in the Covered Person's medical condition that requires the replacement; (2) if the prostheses breaks because it is defective; (3) if the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer; or (4) 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.

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.

Spinal Manipulation Services

Benefits shall be provided up to the limits specified in the ***Schedule of Covered Services*** 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 shall be provided, subject to the Benefit Period Maximums specified in the ***Schedule of Covered Services***, 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.

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**

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.

C. **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).

D. **Infusion Therapy**

Treatment including, but is 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**

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.

F. **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.

G. **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.

H. **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.

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.

SCHEDULE OF COVERED SERVICES

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 Covered Services*** 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 Covered Services*** are not always calculated on actual charges. For an explanation on how Coinsurance is calculated, see the "Covered Expense" definition in the ***Important Definitions*** section.

Covered Services may be provided "In-Network" by a Preferred Provider or "Out-of-Network" by a Non-Preferred Provider. However, the Covered Person will maximize the benefits available when Covered Services are provided In-Network by a Provider that belongs to the Personal Choice Network (a Preferred Provider) and has a contract with the Carrier to provide services and supplies to the Covered Person. The ***General Information*** section provides more detail regarding Preferred and Non-Preferred Providers and the Personal Choice Network.

Some Covered Services must be Precertified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the ***General Information*** section.

Benefit Period	Please refer to your "**Important information about your new group contract**" letter for the Contractholder specific Benefit Period.
Program Deductible	
Family Deductible	
Preferred Care*	The family Deductible amount is equal to $3,000 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 the Family Deductible has been satisfied for all covered family members combined. Deductible described above applies to all Preferred Covered Services except as may otherwise be indicated.

Program Deductible (Continued)

* The Preferred (In-Network) Care Family Deductible amount may be subject to an annual cost of living adjustment for high deductible health plans that are compatible with a health savings account. Any annual adjustment will be made in accordance with Internal Revenue Code section 223. Covered Persons will be notified in advance of any changes to the In-Network Care Family Deductible amount.

Family Deductible

Non-Preferred Care

The family Deductible amount is equal to $10,000 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 the Family Deductible has been satisfied for all covered family members combined.

Deductible described above applies to all Non-Preferred Covered Services except as may otherwise be indicated.

Coinsurance

(Covered Person's Responsibility)

Preferred Care

0% for Covered Services, except as otherwise specified in the ***Schedule of Covered Services***.

Coinsurance described above applies to all Preferred Covered Services except as may otherwise be indicated by the coverage percentages set forth in the following pages.

Non-Preferred Care

50% for Covered Services.

Coinsurance described above applies to all Non-Preferred Covered Services except as may otherwise be indicated by the coverage percentages set forth in the following pages.

Out-Of-Pocket Limit

Family Out-of-Pocket Limit

Preferred Care	After $11,200* of Copayment, Deductible and Coinsurance expense has been Incurred for Preferred Covered Services by Covered Persons in a Family in each Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of that Benefit Period. * The amount of the Preferred (In-Network) Care Family Out-of-Pocket Limit may be subject to an annual cost of living adjustment for high deductible health plans that are compatible with a health savings account. Any annual adjustment will be made in accordance with Internal Revenue Code section 223. Covered Persons will be notified in advance of any changes to the Preferred (In-Network) Care Family Out-of-Pocket Limit amount.
Non-Preferred Care	After $20,000 of Copayment, Deductible and Coinsurance expense has been Incurred for Non-Preferred Covered Services by Covered Persons in a Family in each Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of that Benefit Period. The dollar amount specified above shall not include any expense Incurred for Penalties associated with failure to Precertify required services or for amounts that exceed the Carrier's payment (see the ***Covered Expense*** definition for details).

Lifetime Maximum

Preferred Care	Unlimited.
Non-Preferred Care	Unlimited.

Primary And Preventive Care	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Office Visits	100%	50%
Pediatric Preventive Care Deductibles do not apply.	100%	50%
Pediatric Immunizations Deductibles do not apply.	100%	50%
Adult Preventive Care Deductibles do not apply.	100%	50%
Routine Gynecological Examination, Pap Smear Deductibles do not apply.	100% (one examination per Benefit Period).	50%
Mammograms Deductibles do not apply.	100%	50%
Nutrition Counseling For Weight Management Maximum of six (6) visits per Benefit Period. Preferred Deductible does not apply.	100%	50%

Inpatient Services	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Hospital Services	100% Benefit Period Maximum: 365 Preferred Inpatient days.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is part of, not separate from, Preferred days maximum.
Medical Care	100%	50%
Skilled Nursing Care Facility Maximum of 120 Preferred/Non-Preferred Inpatient days per Benefit Period.	100%	50%

Inpatient/Outpatient Services	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Blood	100%	50%
Hospice Services Respite Care: Maximum of seven (7) days every six (6) months.	100%	50%
Maternity/OB-GYN/Family Services		
Maternity/Obstetrical Care		
Professional Service	100%	50%
Facility Service	100%	50%
Elective Abortions		
Professional Service	100%	50%
Outpatient Facility Charges	100%	50%
Newborn Care	100%	50%
Artificial Insemination	100%	50%

Inpatient/Outpatient Services *Continued*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Mental Health/Psychiatric Care		
Inpatient Treatment Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred Inpatient days.	100%	50%
Mental Health/Psychiatric Care Inpatient days limits are part of, not separate from, the Inpatient Hospital Services days limit.		
Outpatient Treatment Benefit Period Maximum: Twenty (20) Preferred/Non-Preferred Outpatient visits.	100%	50%
Thirty (30) Mental Health/Psychiatric Care Inpatient days may be exchanged for additional Intensive Outpatient Program or Partial Hospitalization Program services or Mental Health/Psychiatric Care Outpatient visits. Each Inpatient day may be exchanged for four (4) Outpatient visits or two (2) Intensive Outpatient Program or Partial Hospitalization Program visits.		

Inpatient/Outpatient Services *Continued*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Inpatient Treatment for Serious Mental Illness Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred Inpatient days.	100%	50%
Outpatient Treatment for Serious Mental Illness Benefit Period Maximum: Sixty (60) Preferred/Non-Preferred Outpatient visits. Each available Inpatient Treatment for Serious Mental Illness day may be exchanged for two (2) additional Intensive Outpatient Program or Partial Hospitalization Program days/Outpatient Treatment sessions.	100%	50%
Surgical Services	100%	50%
Outpatient Anesthesia	100%	50%
Second Surgical Opinion If more than one (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.	100%	50%
Transplant Services		
Inpatient Facility Charges	100%	50%
Outpatient Facility Charges	100%	50%

Inpatient/Outpatient Services *Continued*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Treatment Of Alcohol Or Drug Abuse And Dependency		
Inpatient Hospital Detoxification and Rehabilitation Benefit Period Maximum: Seven (7) days per admission. Lifetime Maximum: Four (4) admissions.	100%	50%
Hospital and Non-Hospital Residential Care Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred Inpatient days. Lifetime Maximum: Ninety (90) Preferred/Non-Preferred Inpatient days. Inpatient treatment days limits are part of, not separate from, the Hospital Inpatient days limits.	100%	50%
Outpatient Treatment Benefit Period Maximum: Sixty (60) Preferred/Non-Preferred Outpatient visits. Lifetime Maximum: 120 Preferred/Non-Preferred Outpatient visits.	100%	50%

Thirty (30) Outpatient Treatment of Alcohol or Drug Abuse or Dependency days may be exchanged on a 2-to-1 basis for fifteen (15) additional days of Non-Hospital Residential Care.

Outpatient Services	If the Covered Person uses a Preferred Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Ambulance Services		
Emergency services	100%	100%
Non-Emergency services	100%	50%
Day Rehabilitation Program Benefit Period Maximum: Thirty (30) visits.	100%	50%
Diabetic Education Program	100%	0% Benefits for Non-Preferred services are not available.
Diabetic Equipment And Supplies	100%	50%
Diagnostic Services		
Routine Diagnostic/Radiology Services	100%	50%
Non-Routine Diagnostic/Radiology Services (including MRI/MRA, CT scans, PET scans)	100%	50%
Laboratory and Pathology Tests	100%	50%
Durable Medical Equipment	100%	50%
Emergency Care Services	100%	100%
Home Health Care	100%	50%

Outpatient Services *Continued*	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Injectable Medications		
Specialty Drug	100%	50%
Standard Injectable Drugs	100%	50%
Medical Foods And Nutritional Formulas	100%	50%
Non Surgical Dental Services (Dental Services as a Result of Accidental Injury)	100%	50%
Orthotics	100%	50%
Podiatric Care	100%	50%
Private Duty Nursing Services Benefit Period Maximum: 360 Preferred/Non-Preferred hours.	100%	50%
Prosthetic Devices	100%	50%
Specialist Office Visits	100%	50%
Spinal Manipulation Services Benefit Period Maximum: Twenty (20) Preferred/Non-Preferred visits.	100%	50%

Outpatient Services ***Continued***	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Therapy Services		
Cardiac Rehabilitation Therapy Benefit Period Maximum: Thirty-six (36) Preferred/Non-Preferred sessions.	100%	50%
Chemotherapy	100%	50%
Dialysis	100%	50%
Infusion Therapy	100%	50%
Orthoptic/Pleoptic Therapy Lifetime Maximum: Eight (8) Preferred/Non-Preferred sessions.	100%	50%
Pulmonary Rehabilitation Therapy Benefit Period Maximum: Thirty-six (36) Preferred/Non-Preferred sessions.	100%	50%
Physical Therapy/Occupational Therapy Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions of Physical Therapy/Occupational Therapy combined. Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.	100%	50%
Radiation Therapy	100%	50%
Speech Therapy Benefit Period Maximum: Twenty (20) Preferred/Non-Preferred sessions.	100%	50%

EXCLUSIONS – 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, except, as approved by the Carrier, Routine Costs associated with a Qualifying Clinical Trial that meets the definition of a Qualifying Clinical Trial under this Booklet/Certificate;

- 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; or as a result of enemy action or act of war, whether declared or undeclared;

- For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;

- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

- Paid or payable by Medicare when Medicare is primary. For purposes of this plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

- For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;

- To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;

- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;

- Which are not billed and performed by a Provider as defined under this coverage as a “Professional Provider”, “Facility Provider” or “Ancillary Provider” except as otherwise indicated under the subsections entitled: (a) "Therapy Services" (that identifies covered therapy services as provided by licensed therapists); and (b) "Ambulance Services" in the ***Description of Covered Services*** section;

- 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 Covered Services***;

- 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 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, unless these drugs are covered by a Prescription Drug Rider or Free-Standing Prescription Drug Contract issued to the Group by the Carrier; or (b) required for treatment of an emergency condition that requires a Self-Injectable Drug;

- 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: (a) the Carrier determines the surgery is Medically Necessary; and (b) the surgery is limited to one (1) 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 Covered Services*** 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 Covered Services*** 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 Covered Services***;

- 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 intellectually disabled 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 Covered Services***;

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

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

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

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

- For contraceptives;

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

- For amino acid supplements, non-elemental 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 Covered Services***;

- 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 intellectually disabled; 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 Covered Services***;

- 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 Covered Services***; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;

- For Cognitive Rehabilitation 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 hearing devices, and hearing examinations or tests for the prescription or fitting of Hearing Aids. Services and supplies related to these items are not covered;

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

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

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

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

OTHER ANCILLARY SERVICES

QCC INSURANCE COMPANY

VISION CARE ADDENDUM

This Addendum is issued to form part of your Booklet/Certificate that describes QCC Insurance Company's Personal Choice Health Benefits Program (**Form No. 16750-BC.SG.I**).

This Addendum changes the provisions, conditions or other terms of your Booklet/Certificate as follows:

I. The "Outpatient Benefits" subsection of the ***Schedule of Covered Services*** is enlarged to include the following:

Outpatient Services	**If the Covered Person uses a Preferred Provider, the Plan will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Plan will pay:**
Vision Care Benefit Period	Once every two (2) Calendar years.	
Vision Care Any Program Deductible(s), Coinsurance amount(s) and Out-of-Pocket Limit(s) reflected in the Schedule of Benefits will apply to Vision Care.		
Routine Eye Exam & Refraction	100% per Vision Care Benefit Period.	100% of the Provider's Charge, up to a maximum of $35.
Eyeglasses, including Spectacle Lenses and Frames, or Contact Lenses	100%, up to a maximum of $100 for all Covered Services per Vision Care Benefit Period; except eye exams and refractive services.	100%, up to a maximum of $100 for all Covered Services per Vision Care Benefit Period; except eye exams and refractive services. This maximum is part of, not separate from, the Preferred maximum.

II. The "Outpatient Services" subsection of the ***Description of Covered Services*** is enlarged to include the following:

Vision Care Benefits

A. **Routine Eye Exam and Refraction**

Subject to the limits shown above, benefits are payable for one (1) routine eye exam and refraction every Vision Care Benefit Period.

B. **Prescription Lenses and Frames from a Preferred Provider**

Subject to the limits shown above, each Covered Person is entitled to the following benefits for vision frames and prescription lenses once every Vision Care Benefit Period when provided by a Preferred Provider:

1. One (1) pair of frames; and

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

3. Contact lenses.

Benefits are also provided for prescription contact lenses in lieu of eyeglasses, up to the limits shown above, once every Vision Care Benefit Period. Additional services are available at a discount through the Preferred Provider.

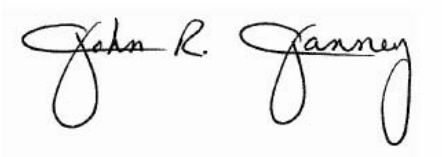
C. **Prescription Lenses and Frames from a Non-Preferred Provider**

Subject to the limits shown above, each Covered Person is entitled to a reimbursement for the cost of corrective lenses, including prescription contact lenses, and eyeglass frames once every Vision Care Benefit Period. The reimbursement amount will be paid when a properly receipted bill is submitted. Instructions for reimbursement may be obtained from the Carrier's Member Services Department.

III. The ***General Information*** is revised as follows:

The provisions reflected in the subsection entitled "Coordination of Benefits" will not apply to any Vision Care benefits contained within this Addendum.

All other terms of the Contract and Booklet/Certificate shall remain in effect.



John R. Janney
SVP Marketing Services

GENERAL INFORMATION

ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THE PLAN

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

Eligible Person

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

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

Eligible Dependent

Your family is eligible for coverage (Dependent coverage) under this Plan when you are eligible for Employee coverage. An eligible Dependent is defined as your spouse under a legally valid existing marriage, your child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. The limiting age for covered children is to the end of the month in which they reach age 26.

A full-time student who is eligible for coverage under this plan who is: (a) 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 thirty (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 thirty (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): (a) notifying the Carrier that the Dependent has been placed on active duty; (b) notifying the Carrier that the Dependent is no longer on active duty; or (c) showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting sixty (60) or more days after his release from active duty.

A "Domestic Partner", as defined below, is also eligible for enrollment. As long as the Domestic Partnership exists the child or children of a Domestic Partner shall be considered for eligibility under the plan as if they were your own child or children. If you enroll your Domestic Partner, you have an affirmative obligation to notify our office immediately if the Domestic Partnership terminates. Upon termination of the Domestic Partner relationship, coverage of the former Domestic Partner and the children of the former Domestic Partner shall terminate at the end of the current monthly term. The former Domestic Partner, and any of his or her previously covered children, shall be entitled, by applying

within sixty (60) days of such termination, to direct pay coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This direct pay coverage may be different from the coverage provided under this Booklet/Certificate.

"Domestic Partner" means a member of a Domestic Partnership consisting of two (2) partners, each of whom: (a) is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time; (b) is not related to the other partner by adoption or blood; (c) is the sole Domestic Partner of the other partner, with whom he or she has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six (6) months; (d) agrees to be jointly responsible for the basic living expenses and welfare of the other partner; (e) meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and (f) demonstrates financial interdependence by submission of proof of three (3) or more of the following documents: (i) a domestic partner agreement; (ii) a joint mortgage or lease; (iii) a designation of one of the partners as beneficiary in the other partner's will; (iv) a durable property and health care powers of attorney; (v) a joint title to an automobile, or joint bank account or credit account; or (vi) such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case. The Carrier reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

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.

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.

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.

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.

Covered Person/Provider Relationship

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

COVERAGE CONTINUATION

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 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:
A. The Group terminates this Plan in favor of group coverage by another organization; or
B. 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.

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. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you through the Carrier by the Group. Continuation of coverage is subject to payment of the applicable premium.

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 or her 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.

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:

A. You, a covered Employee;
B. Your spouse; or
C. 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:

A. Your termination of employment was not due to gross misconduct; and
B. 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:

A. The end of the eighteen (18) month continuation period; and
B. 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 eighteen (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:

A. Your divorce or legal separation from your spouse;
B. Your Dependent child's loss of Dependent eligibility, as defined in this Booklet/Certificate; or
C. 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:

A. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
B. Your death;
C. Your entitlement to Medicare; or
D. 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:

A. His or her right to continue the group health benefits described in this Booklet/Certificate;
B. The monthly premium he or she must pay to continue such benefits; and
C. 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:

A. 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
B. The date the qualified beneficiary notifies the plan administrator, in writing, of your divorce or legal separation from your spouse, or your Dependent child's loss of eligibility.

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

A. The Plan Administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above; or
B. 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 fifty percent (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:

A. 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;

B. 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:
   1. The end of the twenty-nine (29) month period which starts on the date the group health benefits would otherwise end; or
   2. The first day of the month which coincides with or next follows the date which is 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;

C. 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;

D. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
   1. After your termination of employment or reduction of work hours, the end of the 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
   2. 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.

E. The date coverage under this Plan ends;

F. The end of the period for which the last premium payment is made;

G. 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;

H. 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.

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 (2) to nineteen (19) 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 (3)-month period ending with such termination as:

A. You, a covered Employee;
B. Your spouse; or
C. 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:

A. Your termination of employment was not due to gross misconduct;
B. You are not eligible for coverage under Medicare;
C. You verify that you are not eligible for group health benefits as an eligible dependent; and
D. 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:

A. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
B. Your death;
C. Your divorce or legal separation from an eligible dependent;
D. You becoming eligible for benefits under Social Security;
E. Your dependent child ceasing to be a dependent child pursuant to the terms of the group health benefits Booklet/Certificate;
F. 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 (5%) 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:

A. 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;
B. 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;

C. 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;
D. The date coverage under this Plan ends;
E. The end of the period for which the last premium payment is made;
F. 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;
G. The date you and/or eligible dependent become eligible for Medicare.

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INFORMATION ABOUT PROVIDER REIMBURSEMENT

Your Personal Choice Network Plan (this Plan) is a program, which allows you (a Covered Person) to maximize your health care benefits by utilizing the Personal Choice Network, which is comprised of Providers that have a contractual arrangement with the Carrier. These Providers are called "Preferred Providers". You may think of them as "In-Network" Providers. Preferred Providers are doctors, Hospitals and other health care professionals and institutions that are part of the Personal Choice Network, which is designed to provide access to care through a selected managed network of Providers. Services by Preferred Providers are delivered through a selected, managed network of Providers designed to provide quality care. The Personal Choice Network includes Hospitals, Primary Care Physicians and specialists, and a wide range of Ancillary Providers, including suppliers of Durable Medical Equipment, Hospice care and Home Health Care Agencies, Skilled Nursing Facilities, Free Standing Dialysis Facilities and Ambulatory Surgical Facilities.

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

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

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

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

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

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

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

Payment Of Providers

A. Preferred Provider Reimbursement

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

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

1. **Physicians**

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

2. **Institutional Providers**

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

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

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

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

3. **Physician Group Practices, Physician Associations and Integrated Delivery Systems**

Certain physician group practices, independent physician associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with individual physicians to provide medical services. These groups are paid as described in the physicians reimbursement section outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

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

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

B. Payment Methods

A Covered Person or the Provider may submit bills directly to the Carrier, and, to the extent that benefits are payable within the terms and conditions of this Booklet/Certificate, reimbursement will be furnished as detailed below. The Covered Person's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the ***Important Definitions*** section of this Booklet/Certificate.

1. **Facility Providers**

a. **Preferred Facility Providers**

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

b. **Non-Preferred Facility Providers**

Non-Preferred Facility Providers include facilities that are not part of the Personal Choice Network. The Carrier may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network.

The Carrier will provide benefits for Covered Services provided by a Non-Preferred Facility Provider at the Non-Preferred Coinsurance level specified in the ***Schedule of Covered Services.*** The reimbursement rate is specified under "Covered Expense" in the ***Important Definitions*** section of this Booklet/Certificate.

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

Non-Preferred Providers will be the greater of: (1) the median of the amounts paid to Preferred Providers for Emergency Services; (2) the amount paid to Non-Preferred Facility Providers; or (3) the amount paid by Medicare.

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

2. **Professional Providers**

a. **Preferred Providers**

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

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

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

b. **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 ***Important Definitions*** section of this Booklet/Certificate. Inpatient admissions for Emergency Care must be certified within two (2) 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: (1) the median of the amounts paid to

Preferred Providers for Emergency Services; (2) the amount paid to Non-Preferred Professional Providers; or (3) 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.

c. **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 ***Important Definitions*** 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 ***Important Definitions*** section of this Booklet/Certificate.

d. **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 ***Important Definitions*** 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 ***Important Definitions*** section of this Booklet/Certificate.

e. **Non-Preferred Professional Provider Reimbursement**

Except as set forth above, when a Covered Person seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Covered Person at the Non-Preferred Coinsurance level specified in the ***Schedule of Covered Services***. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Booklet/Certificate. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Covered Person will be responsible to reimburse the Non-Preferred Professional Provider for the difference between the Carrier 's payment and the Non-Preferred Professional Provider's charge.

3. **Ancillary Providers**

a. **Preferred Ancillary Providers**

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

b. **Non-Preferred Ancillary Providers**

Non-Preferred Ancillary Providers are not members of the Personal Choice Network. Benefits will be provided to the Covered Person at the Non-Preferred coinsurance level specified in the ***Schedule of Covered Services***. The Covered Person will be penalized

by the application of higher cost sharing as detailed in the ***Schedule of Covered Services***. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Booklet/Certificate. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between the Carrier's payment and the Non-Preferred Ancillary Provider's charge.

4. **Assignment of Benefits to Providers**

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

BlueCard PPO Program

A. **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 the Personal Choice Network service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard PPO 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 Personal Choice Network 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.

1. **BlueCard® PPO Program**

Under the BlueCard® PPO 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 the Personal Choice Network service area and the claim is processed through the BlueCard PPO Program, the amount you pay for covered healthcare services 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 paid 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.

2. **Non-Participating Healthcare Providers Outside the Personal Choice Network Service Area**

   Please refer to the "Covered Expense" definition in the ***Important Definitions*** section of this Booklet/Certificate.

Deductible

You and your covered Dependents must pay a portion of your covered medical expenses before the Carrier begins to pay for benefits. A Deductible must be met each Benefit Period before payment will be made for most Covered Services. There is a family Preferred (In-Network) and Non-Preferred (Out-of-Network) Deductible. See the ***Schedule of Covered Services*** section for the Deductible amounts and the services to which the Deductibles are applicable.

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 is met. Coinsurance is applied to most Covered Services, but not to Covered Services that require you to pay a Copayment amount. See the ***Schedule of Covered Services*** for specific Coinsurance amounts.

Out-Of-Pocket Limit

There is a Maximum placed on the amount of out-of-pocket expenses which you and your covered Dependents are required to pay each Benefit Period. This Maximum is called your "Out-of-Pocket Limit". See the ***Schedule of Covered Services*** for the Preferred (In-Network) and Non-Preferred (Out-of-Network) Out-of-Pocket Limit amounts.

When the In-Network or the Out-of-Network Out-of-Pocket Limit is reached, the Carrier will pay 100% of the Covered Expenses for In-Network or the Out-of-Network Covered Services Incurred during the balance of the Benefit Period. The family In-Network and Out-of-Network Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Covered Services.

Out-of-Pocket expenses Incurred for Preferred Covered Services do not count toward the Non-Preferred (Out-of-Network) Out-of-Pocket Limit.

Out-of-Pocket expenses Incurred for Non-Preferred Covered Services do not count toward the Preferred (In-Network) Out-of-Pocket Limit.

The out-of-pocket amount shall not include any expense Incurred for Out-of-Network Penalties associated with failure to Precertify required services or for amounts that exceed the Carrier's payment (see the definition for "Covered Expense" for more details).

Copayment

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

SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION

Precertification Review

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

While the majority of services requiring Precertification review are reviewed for Medical 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 and is not performed where an agreement with the Carrier's local Preferred or Participating Provider does not require such review.

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

A. **Inpatient Pre-Admission Review**

Preferred Inpatient Admissions

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

Non-Preferred Inpatient Admissions

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

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

2. 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.

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

B. **Emergency Admission Review**

1. **Preferred Admissions**

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

2. **Non-Preferred and BlueCard Provider Admissions**

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

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

c. 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.

C. **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.

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 Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed on the Precertification requirements list, 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.

A. **Preferred Care**

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

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, subject to a Penalty.

For Preferred Providers in the Personal Choice Network, the Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for this financial Penalty for the Preferred Provider's failure to comply with the Precertification requirements or determination, unless a Covered Person elects to receive the treatment after review and written notification that

the procedure is not covered as Medically Necessary. In which case benefits will not be provided and the Covered Person will be financially liable for non-covered charges.

B. **Non-Preferred Care**

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

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty, as reflected 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:

If the Provider is a BlueCard® PPO Provider of another Blue Plan or you use an out-of-network Provider, you must obtain Precertification if required. You will be subject to a 20% reduction in benefits if Precertification is not obtained.

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

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

B. Any procedure, treatment, drug or device that represents “emerging technology”, and

C. 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 ***Important Notices*** section of this Booklet/Certificate that pertain to Experimental/Investigative services, Cosmetic services, Medically Necessary services and Emerging Technology.

Disease Management And Decision Support Programs

Disease Management and Decision Support programs help Covered Persons to be effective partners in their health care by providing information and support to Covered Persons with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Covered Persons with certain chronic diseases, intervening with specific information or support to follow Provider’s treatment plan, and measuring clinical and other

outcomes. Decision Support involves identifying Covered Persons who may be facing certain treatment option decisions and offering them information to assist in informed, collaborative decisions with their Physicians. Decision Support also includes the availability of general health information, personal health coaching, Provider information, or other programs to assist in health care decisions.

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

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

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

Out-Of-Area Care For Dependent Students

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

UTILIZATION REVIEW PROCESS AND CRITERIA

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.

Clinical Criteria, Guidelines And Resources

The following guidelines, clinical criteria and other resources are used to help make Medically 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.

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.

COORDINATION OF BENEFITS

Coordination Of Benefits

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

A. **Definitions**

In addition to the Definitions of this Plan for purposes of is provision only:
"Plan" shall mean any group arrangement providing health care benefits or Covered Services through:

1. Individual, group, (except hospital indemnity plans of less than $200), blanket (except student accident) or franchise insurance coverage;
2. The Plan, health maintenance organization and other prepayment coverage;
3. Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
4. Coverage under any tax supported or government program to the extent permitted by law.

B. **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:

1. If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.
2. If the other Plan includes rules for coordinating benefits:
    a. The Plan covering the patient other than as a Dependent shall be primary.
    b. 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.

c. Except as provided in subparagraph d. 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:
   (1) First, the Plan covering the child as a Dependent of the parent with custody;
   (2) Then, the Plan of the spouse of the parent with custody of the child;
   (3) Finally, the Plan of the parent not having custody of the child.

d. 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.

e. 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 B.2.b.

3. 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.

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

C. **Effect on Benefits**

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

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

Certain facts are needed to apply COB. The Carrier has the right to decide which facts are needed. The Carrier may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Carrier deems necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Carrier such information as may be necessary to implement this provision. The Carrier, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Plan shall be affected by the benefits that would be payable under any and all other Plans only to the extent that the Carrier is furnished with information relative to such other Plans.

D. **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.

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.

CLAIM PROCEDURES

How To File A Claim

You are never required to file a claim when Covered Services are provided by Preferred Providers. When you receive care from a Non-Preferred Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the Carrier's Member Services Department at the number listed on the back of your Identification Card, and a claim form will be sent to you. Fill out the claim form and return it with your itemized bills to the Carrier at the address listed on the claim form no later than twenty (20) days after completion of the Covered Services. The claim should include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered. If it was not possible to file the claim within the twenty (20)-day period, your benefits will not be reduced, but in no event will the plan be required to accept the claim more than two (2) years after the end of the Benefit Period in which the Covered Services are rendered.

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.

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.

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.

Timely Filing

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

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

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

Special Circumstances

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

The Carrier shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Carrier nor the Providers in the Carrier's PPO network shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances as recognized in the community, and by the Carrier and appropriate regulatory authority, are extraordinary circumstances not within the control of the Carrier, including but not limited to: (a) major disaster; (b) epidemic; (c) pandemic; (d) the complete or partial destruction of facilities; (e) riot; or (f) civil insurrection.

COMPLAINT AND APPEAL PROCESS

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

Member Complaint Process

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

General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

Member Appeal Process

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

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

Member Appeals Department	Toll Free Phone: 1-888-671-5276
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820.	Phila. Fax: 215-988-6558

Changes in Member Appeals Process. Please note that the Member Appeals process 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 Member Appeals process, or to reflect other decisions regarding the administration of Member Appeals process for this Plan.

Copies of the Member Appeals Process Descriptions. Descriptions of the timeframes and procedures for the Member Appeals process maintained by the Carrier are available from the following sources:

On the Internet at the Website for the Member's Health Plan. Copies are available there at any time. To see samples of the Member Appeals process, search for "member appeals" in the general search engine. To review a description of the Member Appeals process for the Member's health plan, the Member must log in with the Member's personalized password.

Customer Service. To obtain a description of the Member Appeals process for the Member's health plan, call Customer Service at the telephone number on the back of the Member's Identification Card. Customer Service will mail the Member a copy of the description.

When an Appeal is Filed. As part of the Member Appeal process, a description is provided for the type of Member Appeal that has been filed. The description is sent with the acknowledgment letter for the Member Appeal.

IMPORTANT DEFINITIONS

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

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

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

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

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

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE – Complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM), is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g. homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions (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, nutritional supplements to prevent and treat illness. (e.g. 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 some 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; and (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, 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 or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

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

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

APPLICANT AND EMPLOYEE/MEMBER - you, the Employee who applies for coverage under the 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 Covered Services*** during which charges for Covered Services must be Incurred in order to be eligible for payment by the Carrier. The "specified period of time" may be either a calendar year or a consecutive twelve (12)-month period, called a contract year, that begins on the effective date, and anniversary date thereafter, of the Group Contract. 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 (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 PPO PROGRAM - a program that allows a Covered Person travelling or living outside of their plan's area 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 PPO Program.

BLUECARD PPO PROVIDER - a Provider that participates in the BlueCard PPO Program as a Preferred Participating Provider.

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).

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

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

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, the term "Covered Expense" may not refer to the actual amounts paid by the Carrier to a Provider. Under the Carrier's contracts, the Carrier pays Facility Providers using bulk purchasing arrangements that permit it to pay less for services. The result is that the Carrier is able to offer the Guaranteed Discount to its local Personal Choice customers that receive Covered Services from Facility Providers located in the Carrier's "local service area," i.e. in the five (5) southeastern Pennsylvania counties of Bucks, Chester, Delaware, Montgomery and Philadelphia. The amount the Carrier pays at the time of any given claim may be more and it may be less than the amount used to calculate the Covered Person's liability. Rather, "Covered Expense" means the following:
    1. For Covered Services provided by a Preferred Facility Provider located within the Carrier's local service area, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Guaranteed Discount in effect at the time the services were rendered.

2. For Covered Services provided by a Preferred Facility Provider located outside the Carrier's local service area, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier.
3. 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.
4. 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:
1. For Covered Services by a Preferred Professional Provider or BlueCard PPO 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 PPO Provider.
2. For a Participating Professional Provider, "Covered Expense" means the rate of reimbursement for Covered Services will be made in accordance with the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services;
   * Note that a Participating Professional Provider is not permitted to balance bill the Covered Person.
3. 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:
1. For Covered Services provided by a Preferred Ancillary Provider or BlueCard PPO Provider "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or BlueCard PPO Provider.
2. 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 ***General Information*** 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 (DOMICILIARY 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.

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

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

DETOXIFICATION - the process by which an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a licensed Facility Provider, 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 risk to the patient at a minimum.

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

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

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

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

EFFECTIVE DATE – according to the ***General Information*** section, the date on which coverage for a Covered Person begins under your Personal Choice 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:

- 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

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 active 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.

GUARANTEED DISCOUNT – the percentage reduction from Facility billed charges for Covered Services that the Carrier passes on to its Personal Choice customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts. The balance of any savings not passed on to its customers is for the sole benefit of the Carrier. The amount of the Guaranteed Discount may be changed prospectively from time to time.

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, (a) 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: (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.

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 provider 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 you are actually discharged from the facility.

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

LIMITING AGE FOR DEPENDENTS – the age at which a Dependent child shall be removed from the Employee's coverage. The Limiting Age for covered children is shown in the ***General Information*** section.

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.

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

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

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

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

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

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY) – 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 for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT – the payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

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

MENTAL ILLNESS - any of various conditions categorized as mental disorders by the most current 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 Freestanding 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 is not a member of the Personal Choice Network or is not a BlueCard PPO Provider.

NON-PREFERRED FACILITY PROVIDER - a Facility Provider that is not a member of the Personal Choice Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who is not a member of the Personal Choice Network or is not a BlueCard PPO Provider, or who is not a Participating Professional Provider.

NON-PREFERRED PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider that is not a member of the Personal Choice Network or is not a BlueCard PPO Provider, and for Professional Providers, is not a Participating Professional Provider.

NUTRITIONAL FORMULA - liquid nutritional products which are formulated to supplement or replace normal food products.

OUT-OF-POCKET LIMIT - a specified dollar amount of Covered Expense Incurred by a Covered Person for Covered Services in a Benefit Period. The Out-of-Pocket Limits are calculated as follows:

A. The Preferred Out-of-Pocket Limit expense includes Copayments, Coinsurance and Deductibles, if applicable. When Preferred Out-of-Pocket Limit is reached, the level of benefits is increased as set forth in the ***Schedule of Covered Services***.

B. The Non-Preferred Out-of-Pocket Limit expense includes Coinsurance and Deductible, but does not include any Penalties, Inpatient or Outpatient psychiatric care services, or amounts that exceed the ***Carrier***'s payment (see the definition for "Covered Expense" for more details). When the Non-Preferred Out-of-Pocket Limit is reached, the level of benefits is increased as set forth in the ***Schedule of Covered Services***.

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

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

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

PARTICIPATING PROFESSIONAL PROVIDER - a Professional Provider who has agreed to a rate of reimbursement determined by the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services for the provision of Covered Services to Covered Persons.

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

PERSONAL CHOICE NETWORK – the network of Providers with whom the Carrier has contractual arrangements.

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 a 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 is a member of the Personal Choice Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

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

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

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

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

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

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

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

PRIVATE DUTY NURSING - Medically 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 (RD) – a dietitian registered by a nationally recognized professional association of dietitians. A Registered Dietitian (RD) is a food and nutrition expert who has met the minimum academic and professional requirements to qualify for the credential "RD."

REGISTERED NURSE (R.N.) - a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

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

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

RESIDENTIAL TREATMENT FACILITY - a Facility Provider, licensed and approved by the appropriate government agency and approved by the Carrier, which provides treatment for Mental Illness or 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/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; and (d) the services and supplies required for the diagnosis or treatment of complications.

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

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 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, 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 Covered Person. 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 Carrier.

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** - 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.

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.

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 ***Important Definitions*** section.

Regarding Treatment Which Is Not Medically Necessary:

The Carrier only covers treatment which it determines Medically Necessary. A Preferred/Participating Provider accepts the Carrier's decision and contractually is not permitted to bill the Covered Person for treatment which the Carrier determines is not Medically Necessary unless the Preferred/Participating Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Carrier, and that the Covered Person will be financially responsible for such services. A Non-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/Participating Provider for your care. The term "Medically Necessary" is defined in the ***Important Definitions*** 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 ***Exclusions - What Is Not Covered*** section.

Regarding Coverage For Emerging Technology:

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

effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Covered Person or his or her Provider should contact the Carrier to determine whether a proposed treatment is considered "emerging technology".

Regarding Use Of Non-Preferred Providers

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

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

For specific terms regarding Non-Preferred Providers, please refer to the following sections: ***Important Definitions***; including but not limited to the definition of "Covered Expense" and "Non-Preferred Provider", Payment of Providers and Payment Methods.

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 *General Information* section.

RIGHTS AND RESPONSIBILITIES

To obtain a list of "Rights and Responsibilities", please log on to http://www.ibx.com/members/quality_management/member_rights.html or call the Customer Service telephone number that is listed on your Identification Card to receive a printed copy.

LANGUAGE AND COVERAGE CHANGES

AMENDMENT TO YOUR PERSONAL CHOICE/PPO AGREEMENT

QCC INSURANCE COMPANY

This Notice of Change is issued to form part of your Booklet/Certificate that describes QCC Insurance Company's Personal Choice/PPO Health Benefits Program, a Preferred Provider Organization Health Care Program (Form No. 16750.BC).

This Notice changes the language that describes the provisions, conditions or other terms of the Booklet/Certificate as detailed below.

Effective January 1, 2012:

I. The Important Notices section of the booklet-certificate is expanded to include the following:

Discretionary Authority

The Carrier or Plan Administrator, as applicable, 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 Carrier or Plan Administrator, as applicable, determines in its discretion that the Covered Person is entitled to them.

II. The Defined Terms (Important Definitions) section of the booklet-certificate is expanded to include the following terms:

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.

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.

III. The Defined Terms (Important Definitions) section of the booklet-certificate is revised as follows:

A. The Experimental/Investigative definition 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 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 diagnosis or treatment of the Covered Person'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 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 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 all 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.

B. The Reliable Evidence definition is replaced by 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.

IV. The last sentence of the first paragraph of the Eligible Dependents subsection of the Eligibility Under This Plan (Eligibility, Change and Termination Rules Under The Plan) section of the booklet-certificate is replaced by the following:

The limiting age for covered children is the first of the month following the month in which they reach age 26.

V. The Description of Benefits (Description of Covered Services) is revised as follows:

A. The Rubella Titer Test item under the Pediatric Preventive (if applicable) Care and Adult Preventive Care subsections is replaced by the following:
Rubella Titer Test. The rubella titer blood test checks for the presence of rubella antibodies.

B. The Pediatric Immunization subsection is replaced by the following:

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 Covered Persons under twenty-one (21) years of age.

C. The following Immunization items are removed from the Adult Preventive Care subsection:

- Adult Tetanus Toxoid (TD)
- Influenza Vaccine
- Pneumococcal Vaccine
- Varicella Vaccice
- Certain Immunizations provided to Covered Persons determined to be at “high risk” as determined by the Carrier

D. The Genetic Testing item of the Diagnostic Services subsection is replaced by the following:
Benefits are provided for genetic testing and counseling. Genetic testing and counseling include services provided to a Covered Person 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 carrier, 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.

E. The “Equipment that is not primarily medical in nature” subsection of the Durable Medical Equipment section is replaced by the following:

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, Equipment for Safety, 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.

VI. The Schedule of Benefits (Schedule of Covered Services) is revised as follows:

A. If the Benefit Period applicable to your Plan is Calendar Year the Benefit Period item is replaced by the following:

Benefit Period	Calendar Year (1/1 – 12/31)

B. If the Benefit Period applicable to your Plan is Contract Year the Benefit Period item is replaced by the following:

Benefit Period	Contract Year (12 month period beginning on group's anniversary date)

VII. The What Is Not Covered (Exclusions – What Is Not Covered) subsection is revised as follows:

A. The term "mental retardation" that appears in the exclusion that begins with "For any care that extends beyond traditional medical management" is replaced by the following:

"Intellectual Disability"

B. The exclusion that begins with "For care in a nursing home" is replaced by the following:

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;

VIII. The Termination of Coverage at Termination of Employment or Membership in the Group subsection of the General Information section is replaced by the following:

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 thirty (30) days before the first day of the month in which the Group notified the Carrier of such termination.

Effective January 1, 2013:

The Defined Terms (Important Definitions) section is revised as follows:

I. The Covered Expense definition is replaced by the following:

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, the term "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Facility Provider, “Covered Expense” means the amount payable to the Provider under the contractual arrangement in effect with the Carrier.

ii. 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.

iii. 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 PPO 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 PPO Provider;

ii. For a Participating Professional Provider, “Covered Expense” means the rate of reimbursement for Covered Services will be made in accordance with the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services. * Note that a Participating Professional Provider is not permitted to balance bill the Covered Person.

iii. 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:

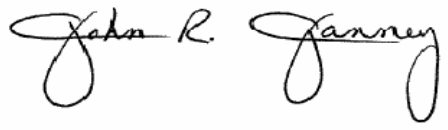
i. For Covered Services provided by a Preferred Ancillary Provider or BlueCard PPO Provider "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or BlueCard PPO Provider.

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.

II. The Guaranteed Discount definition is deleted.

All other terms of your Booklet/Certificate shall remain in effect.



John R. Janney
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