

Important information about Individual health plans

Important notice to persons on Medicare

This insurance duplicates some Medicare benefits.

This is not Medicare Supplement Insurance.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance. This insurance duplicates Medicare benefits:

- Any expenses or services covered by the policy are also covered by Medicare;
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most of all these expenses. Medicare pays benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before you buy this insurance:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Personal Choice® member disclosure

Emergency services

An emergency is defined as 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 placing the member's health, or in the case of a pregnant member, the health of the unborn child, in jeopardy; serious impairment to bodily functions; or dysfunction of any bodily organ or part.

Emergency care includes covered services provided to a member in an emergency, including emergency transportation and related emergency services provided by a licensed ambulance service.

Utilization review

To assist Independence Blue Cross (IBC) in making coverage determinations regarding the medical necessity and appropriateness of requested services, IBC uses medical guidelines based on clinically credible evidence. This is called utilization review. Utilization review can be done before a service is performed (prenotification/precertification/preservice); during a hospital stay (concurrent review); or after services have been performed (retrospective/post-service review). IBC follows applicable state/federal standards pertaining to how and when these reviews are performed.

Complaints and grievances

You have a right to appeal any adverse decision through the complaint and grievance process. Instructions for the appeal will be described in the denial notifications issued to you and in your benefits booklet.

A word about privacy

At IBC, protecting your privacy is very important to us. That is why we have taken numerous steps to see that your protected health information (PHI) is kept confidential. Protected health information is individually identifiable health information about you. This information may be in oral, written, or electronic form. IBC may obtain or create your PHI while conducting its business of providing you with health care benefits.

IBC has implemented extensive policies and procedures regarding the collection, use, and release or disclosure of PHI by and within our organization. We continually review our policies and monitor our business processes to make sure that your information is protected, while assuring that the information is available as needed for the provision of health care services. For example, our procedures include steps to assist us in verifying the identity of someone calling to request PHI, procedures to limit who on our staff has access to your PHI, and to share only the minimum amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks or by using encryption technology if the information is sent by email.

We do not use or share your PHI without your permission unless the law allows us to do so. Before using or disclosing your PHI for other purposes, we'll obtain your written permission, also called an authorization. You may also direct us to share your PHI with someone you chose by giving us your written authorization. However, this authorization must include certain specific information in order to be valid. You may print a copy of our Authorization to Release Information form from our website www.ibx.com or request a copy by calling our Privacy Office at 215-241-4735.

We are permitted to use or disclose your PHI for our payment and health care operations. Examples of these activities include paying claims for services you've received, coordinating the delivery of health care services, and monitoring the performance of our network providers to improve health care outcomes. We may also share your PHI in certain other circumstances, such as disclosures to health care oversight agencies for legally authorized health oversight activities like audits and investigations, or when we are required to do so by law. We may also share certain information with the sponsor of your group health plan so that they may perform their plan administration functions.

The laws that protect your privacy also give you certain rights related to your PHI. For example, you may request a copy of your PHI that we have in our "Designated Record Set." Please remember that IBC does not typically have copies of your medical records. Your health care provider should be contacted for copies of your medical records.

Please review our Notice of Privacy Practices for more detailed information about your privacy rights and how we may use and share your PHI. You may view or print a copy of our notice from our website www.ibx.com by clicking on *Privacy Policy*, or you may call our Privacy Office at 215-241-4735 to request that a copy of the notice be mailed to you.

Creditable coverage FAQs

Preexisting condition exclusions for Individual plans (Personal Choice®, Keystone Health Plan East) and creditable coverage.

Q: What is a preexisting condition exclusion?

A: A preexisting condition exclusion is a denial of coverage for services provided in connection with health conditions that existed before your health insurance policy became effective. If you had a medical condition or illness for which medical advice or treatment was recommended or received within a stated "look-back" period, all claims for this medical condition or illness will be denied by IBC for a certain period of time. Typically, a preexisting condition exclusion period is 12 months. You should review the contract or member materials for your health plan to determine whether your health plan has a preexisting condition exclusion and to identify the related preexisting condition "look-back" period. This preexisting condition exclusion does not apply to enrollees under age 19.

Q: What is creditable coverage?

A: Creditable coverage is the previous health insurance coverage you had that may be used to reduce a preexisting exclusion period for your current coverage. You should review the contract or member materials for your health plan to determine whether your health plan has a preexisting condition exclusion period and to identify the related preexisting condition "look-back" period. This preexisting condition exclusion does not apply to enrollees under age 19.

Q: Do the Individual plans have preexisting condition exclusions?

A: Yes. Like most individual plans, IBC's Individual plans have preexisting condition exclusions. However, the preexisting condition exclusion may not apply if you have enough creditable coverage to waive the exclusion.

Q: When would a preexisting condition exclusion not apply or be reduced for an individual plan?

A: The preexisting condition exclusion in an Individual plan may be reduced if either:

- You had at least one month of coverage from a Blue Cross® and/or Blue Shield® plan and transfer directly into an Individual plan without a break in coverage.
- You had at least one month of coverage from a plan that is an affiliate of Independence Blue Cross and transfer directly into an Individual plan without a break in coverage.

For this "Blue-to-Blue transfer" you will receive credit towards your preexisting condition waiting period for

up to 12 months for the time you were enrolled in the other Blue plan. Your preexisting condition exclusion period will be waived if you enroll in one of two designated Individual Personal Choice plans and you satisfy all of the eligibility requirements of the Health Insurance Portability and Accountability Act (HIPAA):

- You had health care coverage for the past 18 months without a break in coverage.
- Your most recent coverage is group coverage, which can be a governmental plan or church plan. (Note: COBRA coverage is considered group coverage.)
- Your most recent coverage was not terminated because of nonpayment of premium or fraud.
- You no longer qualify for any other group health coverage, Medicare or Medicaid, or coverage under a spouse's policy and have exhausted your COBRA coverage, if available.
- You are not enrolled in an Individual (nongroup) plan or other health care coverage.
- You are applying for continued coverage in one of two designated HIPAA plans within 63 days of the termination date from your group plan.
- You are providing evidence of creditable coverage with a previous insurer. Evidence of creditable coverage may be through documentation (e.g., a Certificate of Continuous Coverage from your previous employer or health insurance identification card) or non-documentary means (e.g., having your previous insurer call IBC or having IBC call your former employer or prior insurer to verify coverage). To discuss how best to provide non-documentary evidence of creditable coverage, call Customer Service at 1-800-453-2566.

Q: May dependents enroll in the Individual plans even if their parents do not enroll?

A: Yes. Dependents may enroll separately from their parents if all other conditions are met. Please note that this is different from most other insurance plans that permit a dependent to enroll only if a parent enrolls. The dependent must meet the conditions for a "Blue-to-Blue transfer" or the conditions under HIPAA in order to reduce or waive the preexisting condition exclusion.

Q: Are there other individual plans that allow an individual to continue coverage without exclusions for preexisting conditions?

A: The adultBasicSM and the Children's Health Insurance Program (CHIP) allow enrollment without exclusions for preexisting conditions. This preexisting condition exclusion does not apply to enrollees under age 19. For information about the Individual plans, call Customer Service at 1-800-453-2566.

Procedures that support safe prescribing

IBC utilizes an independent pharmacy benefits management (PBM) company, FutureScripts®, to manage the administration of its commercial prescription drug programs. As our PBM, FutureScripts is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to our members and providers.

Prior authorization

Prior authorization is a requirement that your physician obtain approval from your health plan for coverage of, or payment for, your medication. IBC requires prior authorization of certain covered drugs to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines. The approval criteria were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing area physicians and pharmacists.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the member's prescribing physician, and the member's available prescription drug therapy history. Their review includes a determination that there are no drug interactions or contraindications, that dosing and length of therapy are appropriate, and that other drug therapies, if necessary, were utilized.

Without prior authorization, the member's prescription will not be covered at the retail or mail order pharmacy (see 96-Hour Temporary Supply Program). The prior authorization process may take up to two working days once complete information from the prescribing physician has been

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received. Incomplete information will result in a delayed decision.

Prior authorization approvals for some drugs may be limited to 6 to 12 months. If the prior authorization for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a member to continue the drug therapy after the expiration date, a new prior authorization request will need to be submitted and approved in order for coverage to continue.

Currently, the drugs listed below are a part of the prior authorization program. Prior authorization applies to all formulations of these specific drugs, including, but not limited to, tablet, capsule, and oral suspension. AcipHex[®], Actiq[®], Adcirca[™], Afinitor[®], Alodex[™], Altanax[™], Ambien CR[®], Amerge[®], Ampyra[™], AMRIX[®], Apidra[®], Apidra[®] SoloSTAR[®], Aplenzin[™], Atacand[®]/Atacand HCT[®], Avapro[®]/Avalide[®], Avidoxy[™]DK, Axert[®], AZOR[®], Banzel[™], Benicar[®]/Benicar HCT[®], Bepreve[™], BiDiL[®], Byetta[®], Caduet[®], Caverject[®], Cayston[™], Celebrex[®], Cesamet[®], Cialis[®], Cimzia[™], Colcris[™], Cozaar[®]/Hyzaar[®], Crestor[®], Daytrana[™], Diabetic Test Strips (except Autodisc[®], Breeze[®] 2, Contour[®], FreeStyle Lite[®] and Precision Xtra[®]), Diovan[®]/Diovan HCT[®], Edex[®], Edluar[™], Effient[™], Enbrel[®], Exalgot[™], Exforge[®], EXFORGE HCT[®], Exjade[®], Fanapt[™], Fentora[®], Flector[®] Patch, Forte[™], Frova[®], Genotropin[®], Gleevec[®], Glumetza[™], Humalog[®], Humatrope[®], Humira[®], Humulin[®], HYCAMTIN[®] Capsules, Imitrex[®], Intuniv[®], Invega[™], Iressa[®], Kapidex[™], Keppra XR[™], Kineret[®], Lantus[®], Levitra[®], Lipitor[®], Livalo[®], Lunesta[®], Lyrica[®], Magnacet[™], Maxalt[®], Micardis[®]/Micardis HCT[®], Mobic[®], MUSE[®], Myobloc[®], Nexavar[®], Nexium[®], Norditropin[®], Noxafil[®], Nucynta[™], NutriDox[™], Nutropin[®], Nutropin AQ[®], Nuvigil[®], Oforta[™], Omnitrope[®], Onglyza[™], Onsolis[™], Opana[®]/Opana[®] ER, Oracea[®], Pataday[™], Pennisaid[®], PrandiMet[™], Prevacid[®], Prevacid/NapraPAC[®], Prilosec[®] Suspension, Pristiq[™], Protionix[®], Provigil[®], Pylera[™], Qualaquin[®], Ranexa[®], ReliON[®]/Novalin[®], Relpax[®], Renvela[®], Requip[®] XL[™], Revatio[®], Revlimid[®], Rozerem[™], Ryzolt[™], Sabril[®], Saizen[®], Samsca[™], Saphris[®], Savella[™], Seroquel XR[®], Serostim[®], Silenor[®], Simcor[®], Simponi[™], Singulair[®], Sprycel[®], Suboxone[®], Subutex[®], Sumavel[™], Sutent[®], Symlin[®], Taclonex[®], Taclonex Scalp[®] Suspension, Tarceva[®], Tassigna[®], Tektuma[®]/Tekturna HCT[®], Temodar[®] Oral, Teveten[®]/Teveten HCT[®], Tev-Tropin[®], Thalomid[®], Toviaz[™], Treximet[™], Twynsta[®], Tykerb[®], Uloric[®], Ultram[®] ER, Valturma[®], Vectical[™], Veramyst[™], Viagra[®], Victoza[®], Vimovo[®], Vimpat[™], Voltaren[®] Gel, Votrient[™], Vytorin[®], Vyvanse[™], Xenazine[™], Xyzal[®], Zelapar[®], Zipsor[™], Zmax[™], Zolanza[®], Zorbtive[®] and Zyvox[®]. This list is subject to change.

Age and gender limits

The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals 14 and older, such as Ciprofloxacin[®], or prescribed only for females, such as prenatal vitamins. The pharmacist's computer provides up-to-date information about FDA rules. If the member's prescription falls outside of the FDA guidelines, it will not be covered until prior authorization is obtained. The prescribing physician may request preapproval of restricted medications when medically necessary. The approval criteria for this review were developed and endorsed by the FutureScripts Pharmacy and Therapeutics Committee, which is an established group of medical directors and practicing area physicians and pharmacists. The member should contact the prescribing physician to request that he or she initiate the preapproval process. To determine if a covered prescription drug prescribed for you has an age or gender limit, call FutureScripts at 1-888-678-7012.

Quantity level limits

Quantity level limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses and length of therapy of a particular drug. We have several different types of quantity level limits, which are explained in detail below.

Rolling 30-day period. This quantity limit is based on dosing guidelines over a rolling 30-day period. Examples of quantity level limits per rolling 30-day period are Emend[®]

(four 125mg capsules + eight 80mg capsules) or four trifold packs [one 125mg capsule + two 80mg capsules]; Boniva[®] (two 150mg tablets); Avonex[®] (one kit, four injections); Betaseron[®] (15 vials); Copaxone[®] (32 vials); Fosamax Plus D[™] (five tablets); Rebif[®] (12 injections); migraine drugs such as Amerge[®] (nine 2.5mg tablets), Imitrex[®] (36 50mg tablets), Maxalt[®] (12 10mg tablets), Migranal[®] (eight 4mg nasal spray units), Stadol NS[®] (four 10mg units), and Zomig[®] (nine 5mg tablets); sedative hypnotic drugs, such as Sonata[®] (14 capsules) and Ambien[®] (14 tablets); and oral narcotic drugs such as OxyContin[®] (90 units), Percocet[®] (180 units), and Percodan[®] (180 units). For example, if a member went to the pharmacy on October 1, 2009, for one of these medications, the computer system would have looked back 30 days to September 1, 2009, to see how much medication was dispensed. The purpose of these limits is to make certain that these drugs are being used appropriately and to guard against overuse or stockpiling.

Refill too soon. With this quantity level limit, if a member used less than 75 percent of the total day supply dispensed, the claim will be rejected at the pharmacy. This will ensure that the medication is being taken in accordance with the prescribed dose and frequency of administration.

Therapeutic drug class. This quantity level limit applies to some classes of drugs, such as narcotics (i.e., short-and-long-acting). If a member uses more than one drug within the same class, he or she may be unsafely duplicating medications and would be affected by the total quantity limits for a therapeutic drug class. Members will be able to obtain only a 30-day total supply of any combination of drugs in the same therapeutic drug class each month.

If a physician requires that a member needs a medication therapy that exceeds any of the quantity level limits described above, the physician must request a quantity limit override. The member is required to contact the prescribing physician to initiate a preapproval request for an override.

Some drugs may have a time period for quantity limit exceptions of 6 to 12 months. If the exception for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the physician wants a member to continue the drug therapy that exceeds a quantity limit after the expiration date, a new request for a quantity limit exception will need to be submitted and approved in order for coverage to continue.

To determine if a covered prescription drug prescribed for you has a quantity level limit, call FutureScripts at 1-888-678-7012.

96-Hour Temporary Supply Program

The 96-Hour Temporary Supply Program applies to the following covered medications:

- most medications that require prior authorization;
- medications that are subject to age limits (preapproval required for ages outside of recommended ranges);
- migraine medications with quantity level limits, such as Amerge[®], Imitrex[®], Maxalt[®], Migranal[®], Stadol NS[®], and Zomig[®] (preapproval of quantity override required for amounts over the quantity level limits).

Under the 96-Hour Temporary Supply Program, if a member's doctor writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity level limit for a medication, and prior authorization/preapproval has not been obtained by the doctor, the following steps will occur:

1. The participating retail pharmacy will be instructed to release a 96-hour supply of the drug to the member with no out-of-pocket cost-sharing at that time.*
2. By the next business day, our PBM will contact the member's doctor to request that he or she submit the necessary documentation of medical necessity or medical appropriateness for review.
3. Once the completed medical documentation is received by our PBM, the review will be completed and the medication will be approved or denied.
4. If approved, the remainder of the prescription order will be filled, and the appropriate prescription drug out-of-pocket cost-sharing will be applied.*
5. If denied, notification will be sent to the doctor and the member.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization/preapproval request will be approved. Some medications are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations, such as Retin-A[®] (tube), Enbrel[®] (2-week injection kit), medroxyprogesterone acetate (monthly injectable), and erectile dysfunction drugs. Additionally, certain drugs to treat hemophilia (antihemophilic factors) are not usually purchased at the pharmacy and must be special-ordered; therefore, they are not eligible for the 96-hour temporary supply.

The process for requesting a prior authorization/preapproval or override is as follows:

- The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and submits it to our PBM by fax at 215-241-3073 or 1-888-671-5285. A member's physician may request the form by calling 1-888-678-7012. Members may request the form through Customer Service on behalf of their physician, but it must be completed and submitted by the doctor.
- The PBM will review the prior authorization request or letter of medical necessity. If a clinical pharmacist can not approve the request based on established criteria, a medical director will review the document.
- A decision is made regarding the request.
- If approved, the prescribing physician will be notified of approval via fax or telephone, and the Rx Claim System will be coded with the approval.
- The member may call the Customer Service phone number on his or her identification card to determine if the prescription is approved.
- If denied, the prescribing physician will be notified via letter, fax, or telephone.
- The member is also notified of all denied requests via letter.
- The appeals process will be detailed on the denial letters sent to the member and physician.

Coverage for medications not on the formulary (specific to Select Drug Program[®] members only)

Providers may request formulary coverage of a covered non-formulary medication when all formulary alternatives have been exhausted or there are contraindications to using the formulary alternatives. The provider should complete the covered non-formulary appeal form providing detail to support use of the covered non-formulary medication and fax the request to 215-241-3073 or 1-888-671-5285. If the nonformulary request is approved, the drug will be paid at the appropriate formulary benefit level. If the request is denied, the member and provider will receive a denial letter with the appropriate appeals language. Whether or not an appeal is filed, the member may always obtain benefits for the covered non-formulary drug at the appropriate non-formulary benefit level. Out-of-pocket expenses for non-formulary drugs are higher than for formulary drugs.

Appealing a decision

If a request for prior authorization/preapproval or override results in a denial, the member, or the physician on the member's behalf, may file an appeal. Both the member and his or her provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. In all cases, the physician needs to be involved in the appeal process to provide the required medical information for the basis of the appeal.

Prescription drug program provider payment information

A PBM administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. IBC anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefit plans, prescription drugs are subject to a member copayment.

*Members with an integrated drug benefit (e.g., CMM and Major Medical) will pay the discounted cost of the 96-hour supply as well as the remainder of the prescription order (if approved at the time of purchase, and the medical claim for reimbursement will be processed through standard procedures).



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