Everything you need to know about your health plan

Independence
Keystone Health Plan East

Questions?

Visit ibxpress or

Call 1-800-ASK BLUE
(TTY: 711)

Welcome to Independence Blue Cross

Thank you for choosing Independence Blue Cross. Our goal is to provide you with health care coverage that can help you manage your health care needs. This Benefit Booklet will help you understand your Independence coverage so that you can take full advantage of your membership by becoming familiar with the benefits and services available to you.

You'll find valuable information on:

- How to select a Primary Care Physician.
- What services are and are not covered by your health insurance.
- How decisions are made about what is covered.
- How to use our member website, ibxpress.com.
- How to get in touch with us if you have a problem.

If you have any other questions, feel free to call Customer Service at 1-800-ASK-BLUE (TTY: 711) and we will be happy to assist you.

Again, thank you for being a member of Independence Blue Cross. We look forward to providing you with quality health care coverage.

Introduction to your health plan

What is a primary care physician?

You have a Keystone Health Plan East HMO, which means you must choose a primary care physician (PCP) who will coordinate the overall medical care for you and your covered dependents. Your PCP is the doctor that will treat you for your basic health care needs.

Anytime you need to see a specialist, such as a cardiologist or dermatologist, your PCP will refer you to a specialist participating in the network. PCPs choose one radiology, physical therapy, and laboratory site to which they send their patients. If you need a service your PCP doesn't provide, like diagnostic testing or hospitalization, your PCP will refer you to an in-network facility.

How you choose or change your PCP

To select or change your PCP, search our provider network. Visit www.ibx.com/providerfinder where you can search by specialty (for example internal medicine or pediatrics), location, gender preference, and distance.

There are two ways to choose or change your PCP:

Online: To select or change your doctor, visit www.ibxpress.com, our simple, convenient, and secure member website. Click on the Change my Primary Care Physician link under the Find a Doctor or Hospital section.

Phone: Call 1-800-ASK-BLUE (TTY: 711) and one of our Customer Service associates will take your PCP selection over the phone.

Using your ID card

You and your covered dependents will each receive an Independence Blue Cross identification (ID) card. It is important to take your ID card with you wherever you go because it contains information like what to pay when visiting your doctor, specialist, or the emergency room (ER), and your PCP's contact information. You should present your ID card when you receive care, including doctor visits or when checking in at the ER.

Independence

The back of your ID card provides information about medical services, what to do in an emergency situation, and how to use your benefits.

If any information on your ID cards is incorrect, you misplace an ID card, or need to print out a temporary ID card, you may do so through www.ibxpress.com, our member website.

IBX Wire

When you receive your ID card, call the toll-free number on the sticker affixed to the card to confirm receipt. You will also be given the option to sign up for IBX Wire, a free messaging service. IBX Wire is an innovative way for you to receive timely and helpful communications on your smartphone. If you choose to opt in, you will have access to a private message board and will receive text messages about once every other week that communicate helpful, relevant information about your health plan, maximizing your benefits, and wellness programs.

Locating a network physician or hospital

You have access to our expansive provider network of physicians, specialists, and hospitals. You may search our provider network by going to www.ibx.com/providerfinder. You may search by specialty (e.g. internal or pediatrics), location, gender preference, and distance. You may also call 1-800-ASK-BLUE (TTY: 711) and a customer service associate will help you locate a provider.

How to receive care

Scheduling an appointment
Simply call your doctor's office and request an appointment. If possible, call network providers 24 hours in advance if you are unable to make it to a scheduled appointment.

Referrals

You are required to get a referral from your PCP for specialty services. All referrals are done electronically, so you can get the care you need as quickly and conveniently as possible. You won't need a referral for OB/GYN care, mammograms, mental health, or routine eye care. You may also check the status of your referral by logging on to ibxpress.com or on your iPhone or Android through the IBX App.

Services that require preapproval before receiving care

As a Keystone Health Plan East member, certain in-network services and all out-of-network services require preapproval prior to receiving care to ensure that the service you seek is medically necessary. Since your care is provided by your PCP, all necessary preapprovals will obtained for you by your PCP. It is important to understand that preapproval is not the same as the process for receiving referrals from your PCP.

Using your preventive care benefits

Quality care and prevention are vital to your long-term health and well-being. That's why we cover 100 percent of certain preventive services, offering them without a copayment, coinsurance, or deductible if received from your PCP or other in-network provider.

Sign up for IBX Wire

When you receive your ID card, opt in to IBX Wire to receive text messages about your health plan.

Covered preventive services include, but are not limited to:

- screenings for:
  – breast, cervical, and colon cancer
  – vitamin deficiencies during pregnancy
  – diabetes
  – high cholesterol
  – high blood pressure
- routine vaccinations for children, adolescents, and adults as determined by the CDC (Centers for Disease Control and Prevention).
- women's preventive health services, such as:
  – well-woman visits (annually);
  – screening for gestational diabetes;
  – human papillomavirus (HPV) DNA testing;
  – counseling for sexually transmitted infections;
  – counseling and screening for human immunodeficiency virus (HIV);
  – screening and counseling for interpersonal and domestic violence;
  – breastfeeding support, supplies (breast pumps), and counseling;
  – generic formulary contraceptives, certain brand formulary contraceptives, and FDA-approved over-the-counter female contraceptives with a prescription.

Be sure to consult with your PCP for preventive services and/or screenings.

Wellness Guidelines
Your health and wellness are important. That's why we provide you with these nationally recommended tests and screenings to help you and your family stay healthy. We encourage you to take the time to review these guidelines and discuss them with your health care provider. Some of these services may require cost-sharing. * Additional resources along with tips to stay healthy and safe and topics to discuss with your health care provider are included.

To download our Wellness Guidelines, log on to www.ibxpress.com and click on the Health & Wellness Programs tab. Then click on Healthy Living, and then on Wellness Guidelines. You can also request a hard copy of the Wellness Guidelines
by calling 1-800-ASK-BLUE (TTY: 711).

*The Wellness Guidelines are a summary of recommendations based on the U.S. Preventive Services Task Force and other nationally recognized sources. These recommendations have been reviewed by our network health care providers. This information is not a statement of benefits. Please refer to your health benefit plan contract/member handbook or benefits handbook for terms, limitations, or exclusions of your health benefits plan. Please contact our Customer Service department with questions about which preventive care benefits apply to you. The telephone number for Customer Service can be found on your ID card.

Emergency care

In the event of an emergency, go immediately to the emergency room of the nearest hospital. If you believe your situation is particularly severe, call 911 for assistance.

A medical emergency is typically thought of as a medical or psychiatric condition in which symptoms are so severe, that the absence of immediate medical attention could place one's health in serious jeopardy. Most times, a hospital emergency room is not the most appropriate place for you to be treated.

Hospital emergency rooms provide emergency care and must prioritize patients' needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you could wait a long time.

Urgent Care

Urgent care is necessary treatment for a non-life-threatening, unexpected illness or accidental injury that requires prompt medical attention when your doctor is unavailable. Examples include sore throat, fever, sinus infection, ear ache, cuts, rashes, sprains, and broken bones.

You may visit an urgent care center which offers a convenient, safe, and affordable treatment alternative to emergency room care when you can't get an appointment with your own doctor.

Retail health clinic

Retail health clinics are another alternative when you can't get an appointment with your own doctor for non-emergency care. Retail health clinics use certified nurse practitioners who treat minor, uncomplicated illness or injury. Some retail health clinics may also offer flu shots and vaccinations.

Not sure what facility to use? Go to www.ibx.com/findcarenow to help you decide where to go for care.

You're covered while traveling

You can travel with the peace of mind knowing that Blue goes with you wherever you go. If you need medical care when you are away from home, you should follow these guidelines:

- In a true emergency, go to the nearest ER.
- In an urgent care situation, find a provider in the area. Call 1-800-810-BLUE (TTY: 711) to find an in-network provider in the area. You may also visit an urgent care center for medical issues if an in-network provider is unavailable and if you do not require the medical services of an emergency room.
- Prior to visiting a physician's office, it will be necessary for you to obtain a preapproval.

Guest membership

Guest membership is a temporary courtesy enrollment in another HMO (Host) plan that enables members who are living away from home to receive a comprehensive range of medical benefits, including routine and preventive services. A Guest Member remains an IBC member, pays premiums to IBC, but is also enrolled to receive benefits of the host plan while in their service area.

Keystone Health Plan East subscribers may be eligible to be on a Guest Membership for up to a 12 month period (6 months followed by 6 months upon approval of a renewal request). Dependents may be eligible to be on a Guest Membership for a period of up to 12 months without a renewal request. Members who are eligible to participate must also meet the following criteria:

- Long-term traveler — available to qualified HMO subscribers and dependents that are away from home for at least 90 consecutive days (3 months), but not more than 180 days (6 months) or group renewal date.
- Families apart — available to qualified dependents of the subscriber that do not reside in our service area for 90 or more consecutive days.
- Students — available to qualified dependents of the subscribers that are out of our service area for 90 or more consecutive days attending school.

For example

When to go to the ER:
- heart attack
- electrical burn

When to go to an urgent care center:
- sore throat
- ear ache

Out of the area and need care?

Call 1-800-810-BLUE (TTY: 711) to find an in-network provider in the area.

Register on ibxpress.com to access your benefits online.

Receiving services for mental health, alcohol, or substance abuse treatment

If you require outpatient or inpatient mental health or substance abuse services, a written referral from your PCP is not necessary. Magellan Behavioral Health administers your Keystone Health Plan East mental health and substance abuse benefits and can be reached by calling 1-800-ASK-BLUE (TTY: 711). Refer to the terms and conditions of your group health plan to find out if you have coverage for mental health and substance abuse benefits.

Stay Connected

On ibxpress.com you can conveniently and securely view your benefits and claims information and use the tools that help you take control of your health. As an Independence Blue Cross member, you and your dependents 14 years of age and older can create your own accounts on ibxpress.com.

Register on ibxpress.com

To register, simply go to ibxpress.com, click *Register*, and then follow the directions. You will need information from your ID card to register, so be sure to have it handy.

Once you're registered, log on to ibxpress.com to:

- view your benefits information;
- review claims information;
- review annual out-of-pocket expenses;
- request a replacement ID card and print a temporary ID card;
- change your PCP;
- view and print referrals;
- download forms.

Online tools to help make informed health care decisions

ibxpress.com also provides you with tools and resources to help you make informed health care decisions:

Provider Finder and Hospital Finder help you find the participating doctors and hospitals that are equipped to handle your needs. Simple navigation helps you get fast and accurate results. Plus, when you select your health plan type your results are customized based on your network, making it easy to locate a participating doctor, specialist, hospital, or other medical facility. You'll even be able to read patient ratings and reviews and rate your doctors and write your own reviews.

Symptom checker provides a comprehensive tool to help you understand your symptoms – and what to do about them.

- **Health Encyclopedia** provides information on more than 160 health topics and the latest news on common conditions.
- **Treatment Cost Estimator** helps you estimate your costs within certain geographic areas for hundreds of common conditions — including tests, procedures, and health care visits, so you can plan and budget for your expenses. You even have access to tools and programs to help you make lifestyle changes by helping you get started, setting reachable goals, and giving you ways to track your progress.

- **Personal Health Profile** gives a clear picture of what you are doing right and ways to stay healthy. After completing the Personal Health Profile, you will receive a confidential and personalized action plan.
- **My Health Assistant** is a personal coaching tool that provides an interactive, targeted approach to healthy behavior change.
- **Health Trackers** allow you to track your blood pressure, cholesterol, body fat, and even exercises.
- **Personal Health Record** helps you store, maintain, track, and manage your health information in one centralized and secure location. Your Personal Health Record is updated once we process claims received from participating providers.

Manage your health on the go with the IBX App

Download the free IBX App for your smartphone to help you make the most of your health plan. The IBX App gives you easy access to your health care coverage 24/7, wherever you are. Use the Doctor's Visit Assistant on the IBX App to:

- view and share your ID card
- check the status of referrals and claims
- access your health history and prescribed medications
- record notes and upload photos of symptoms to discuss with your doctor

The IBX App also offers expanded provider search capabilities and other ways to manage your health on the go:

- find doctors, hospitals, urgent care centers, and Patient-centered Medical Homes
- access benefit information
- track deductibles and spending account balances

Download from the App store or Google Marketplace. Log in to the App with the same username and password you use for ibxpress.com.

Download the IBX App

After you download the IBX App, simply use your ibxpress.com username and password to log in.

Save money with wellness discounts from Blue365®

You can enjoy exclusive value-added discounts and offers on programs and services from leading national companies. Blue365 gives you an easy-to-use, valuable resource to save on healthy programs and services. Visit www.blue365deals.com to see the latest discounts.

Connect with us on Facebook and Twitter

"Like" the Independence Blue Cross page on Facebook or follow us on Twitter, and you'll find a whole new approach to making healthy lifestyle changes, one step at a time.

- Receive health and wellness tips that can help you improve your well-being.
- Enter contests and promotions.
- Connect with other health-minded fans.
- Learn how to incorporate fitness, good nutrition, and stress management into your everyday life with practical advice.

Follow us!

www.facebook.com/ibx
www.twitter.com/ibx

Your one-stop shop

ibxpress.com

Customer Support

When you need us, we're here for you. You can contact us to discuss anything pertaining to your health care, including:

- benefits and eligibility
- claims status
- requesting a new ID card
- wellness programs

Email

To send a secure email to Customer Service, log on to www.ibxpress.com and click on the *Contact Us link*. On the Contact Us page you will see a link that allows you to send your inquiries or comments directly to Customer Service.

Mail

Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

Our walk-in service, located at 1919 Market Street, 2nd Floor, is open Monday through Friday from 8 a.m. to 5 p.m.

Call

Call 1-800-ASK-BLUE (TTY: 711) to speak to one of our experienced Customer Service team members, who are available to answer your questions Monday through Friday, 8 a.m. to 6 p.m.

Services for members with special needs

If a language other than English is your primary language, call Customer Service at 1-800-ASK-BLUE (TTY: 711) and they will work with you through an interpreter over the telephone to help you understand your benefits and answer any questions you may have.

Key terms

You will find key terms and definitions in detail included in the benefit booklet. You may also view the glossary of key terms in Health Care Reform by visiting ibx.com/HCR_Glossary.

Independence

Pharmacy

Using your prescription drug benefits

Find out how to fill prescriptions

Independence Blue Cross Prescription Drug Program

Your prescription drug benefit program, administered by FutureScripts®, an independent company, provides many advantages to help you easily and safely obtain the prescription drugs you need at an affordable cost.

Take a look at the advantages:

- **Easy to use**. A national network of retail pharmacies will recognize and accept your member identification (ID) card.
- **Low out-of-pocket expenses**. When you use a participating pharmacy, your out-of-pocket costs are based on a discounted price, fixed copayments, or coinsurance.
- **No paperwork**. You don't have to file a claim form or wait for reimbursement when you use a participating pharmacy.
- **High level of safety**. When you fill a prescription at a participating pharmacy, your pharmacy can identify harmful drug interactions and other dangers by viewing your drug history.
- For maintenance drugs needed to treat ongoing or chronic conditions
  - **Home delivery**. Your program may allow you to receive drugs right at your door when ordered through the mail order service, eliminating time spent waiting in line at the pharmacy counter.
  - Mail order purchases allow you to get a larger supply of drugs than what might be available to you at the retail pharmacy. And, depending upon your plan design, your out-of-pocket expenses may be lower and you won't have to visit the pharmacy as often.

How to fill your prescription at a retail pharmacy

Present your ID card and your prescription at a FutureScripts participating pharmacy for your plan. The pharmacist will confirm your eligibility for benefits and determine your share of the cost of your prescription. Your doctor may also electronically submit your prescription to your pharmacy.

Participating pharmacies

A pharmacy is considered participating if it is in the FutureScripts pharmacy network for your plan. The FutureScripts network is a large national network of retail pharmacies. When you're traveling, you will find that most of the pharmacies in all 50 states accept your ID card and can fill your prescription for the same cost you pay at home, if you use a participating pharmacy.

There is no need to select just one pharmacy to fill your prescription needs.

To locate a participating pharmacy, visit www.ibxpress.com or call the number on your ID card.

Find a pharmacy

Visit www.ibxpress.com or call the number on your ID card.

FUTURE SCRIPTS

Non-participating pharmacies

If your prescription is filled at a pharmacy that does not participate in the network for your plan, you will have to pay the pharmacy's regular charge right at the counter. Then, depending on your plan design, you may submit a prescription reimbursement claim form for partial reimbursement to the address noted on the form. Your reimbursement check should arrive within 14 days from the day your claim form is received.

Keep in mind that your plan sponsor selected Independence Blue Cross (IBC) and/or its subsidiaries based in part on the discounted drug prices that FutureScripts has negotiated. When you use a non-participating pharmacy that has not agreed to charge a discounted price, it costs your plan more money; part of that cost is passed on to you.

If you have any questions about your IBC Prescription Drug program, call the pharmacy benefits number on the back of your ID card.

Understanding your prescription

A brand drug is manufactured by only one company, which advertises and sells its product under a special trade name. In many cases, brand drugs are quite expensive, which is why your share of the cost is higher. Generic drugs are typically manufactured by several companies and are almost always less expensive than the brand drug. Generic drugs are approved by the U.S. Food and Drug Administration (FDA) to ensure they are as safe and effective as their brand counterparts. However, not every brand drug has a generic version.

We provide our members with comprehensive prescription drug coverage. The drug formulary includes generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. The formulary is reviewed regularly to ensure its continued effectiveness.

To check the formulary status of drugs, simply log onto ibxpress.com.

In addition to the drug formulary, you will also find helpful information on these related topics:

- Prior authorization process
- Age and quantity level limits

If you're not sure if brand or generic drugs are right for you, talk to your doctor. The pharmacist may, on occasion, discuss with your physician whether an alternative drug might be appropriate for you. Let your physician know if you have a question about a change in prescription or if you prefer the original prescription. Your physician makes the final decision on the necessity of you getting a brand drug.

Certain controlled substances and other prescribed medications may be subject to dispensing limitations. If you have any questions regarding your medication, please call the Pharmacy Benefits number on the back of your ID card.

Brand vs. Generic

Generic drugs are as effective as brand drugs and could save you money. However, consult your doctor to find out which drug type is best for you.

Preventive drugs for adults and children

IBC's prescription drug plans include 100-percent coverage for some preventive medications when received from an in-network pharmacy. This means that you won't have to pay copays, coinsurance, or deductibles for certain preventive medications with a prescription from your doctor. Receiving this preventive care will help you stay healthy and may improve your overall health.

For a list of preventive drugs eligible for 100-percent coverage please go to www.ibx.com or call the phone number on the back of your ID card.

Mail order pharmacy

If your doctor has prescribed a medication that you'll need to take regularly over a long period of time, the mail-order service is an excellent way to get a long-lasting supply and, depending on your plan, reduce your out-of-pocket costs.

Mail order is convenient and safe to use

If you choose mail order, your doctor can prescribe a supply that will last up to 90 days. This means that you can get three times as many doses of your maintenance medication at one time through mail order.

Mail order prescriptions have been safely handled through the mail for many years. When your order is received, a team of registered, licensed pharmacists checks your prescription against the record of all drugs dispensed to you by a FutureScripts network pharmacy. This process ensures that every prescription is reviewed for
safety and accuracy before it is mailed to you.

If there are questions about your prescription, a pharmacist will contact your doctor before your medication is dispensed. Your medication will be sent to your home within ten days from the date your legible and complete order is received. There may be times when you need a prescription right away. On these occasions, you should have your prescription filled at a local participating pharmacy. If you need medication immediately, but you will be taking it on an ongoing basis, ask your doctor to write two separate prescriptions: you can have the first prescription filled locally for an initial 30-day supply of your medication, and you can send the second prescription to FutureScripts for a 90-day supply provided through the mail.

On-line services

Log on to www.ibxpress.com and click on Manage My Prescription Drugs to take advantage of convenient features, such as:

- network pharmacy search
- formulary search
- claims information
- mail-order refill requests

How to begin using mail order pharmacy:

1. When you are prescribed a chronic or "maintenance" drug therapy, ask your doctor to write the prescription for a 90-day supply, plus refills. Make sure your doctor knows that you have a mail-order service so that you get one 90-day prescription and not three 30-day prescriptions, because the cost of the three
30-day prescriptions may be more than the cost for one 90-day prescription.
If you're taking medication now, ask your doctor for a new prescription.

2. Complete the *FutureScripts Mail Service Order Form* with your first order only. Forms and envelopes are available by calling the number on your ID card, or you can download the form from www.ibxpress.com.

3. Be sure to answer all the questions, and include your member ID number. An incomplete form can cause a delay in processing. Send the completed *Mail Service Order Form,* your original 90-day prescription, and your payment instructions to FutureScripts.

4. Your mail order request will be processed and your medication sent to you within 14 days from the day FutureScripts receives your order, along with instructions for future refills. Standard shipping is via U.S. Mail and is free of charge. Narcotic substances and refrigerated medicines will be shipped by FedEx® at no additional charge. Your order will be shipped to the address you provided on the form.

How can my doctor order a prescription for me?

Doctors may call our toll-free number to prescribe your medication(s).

Doctors may fax prescriptions. In addition to the prescription information your doctor must provide member ID number, patient name and patient date of birth. Note: To be legally valid, the fax must originate from the physician's office. All state laws apply.

You will be dispensed the lower-priced generic drug (if manufactured) unless

your doctor writes "brand medically necessary" or "dispense as written" on your prescription, or you indicate that you do not want the generic version of your brand drug on the Mail Service Order Form. A *Mail Service Order Form* will be included with each mail order delivery.

Paying for mail order services

Your payment can be a check or money order (made payable to FutureScripts), or you can complete the credit card portion of the *Mail Service Order Form*. FutureScripts accepts Visa, MasterCard®, Discover®, and American Express®. Please do not send cash. If you are uncertain of your payment, call the number on your ID card. If the payment you enclose is incorrect, you will be sent either a reimbursement check or an invoice, as appropriate.

Mail order refills

When you receive a medication through the mail order service, you will also receive a notice showing the number of refills allowed by your doctor. To avoid the risk of being without your medication, mail the refill notice and your payment two weeks before you expect your present supply to run out. You can also manage and order your refills online through ibxpress.com or over the phone using the pharmacy benefits number on the back of your ID card.

The refill notice will include the date when you should reorder and the number of refills you have left. Remember, most prescriptions are valid for a maximum of one year. Please note: PRN (take as needed) refills in the Commonwealth of Pennsylvania are limited to five times or six months, whichever is less.

If you have any questions concerning this program, please contact FutureScripts using the phone number on the back of your ID card.

Self-administered Specialty Drug Coverage

Self-injectables and other oral specialty drugs that can be administered by you, the patient, or by a caregiver outside of the doctor's office are covered under your IBC prescription drug benefits administered by FutureScripts. Filling your prescription for a specialty drug via the FutureScripts Specialty Pharmacy Program can save you money and provide you with support by a pharmacist very experienced with specialty medications and their side-effects.

The administration of a self-injectable drug by a medical professional is covered under your IBC medical benefit, even if you obtained the self-injectable through the FutureScripts Specialty Pharmacy Program. However, the drug itself will be covered under your IBC prescription drug benefit.

The self-injectable drugs that are covered under IBC medical plans include drugs that:

- are required by law to be covered under both medical benefits and pharmacy benefits (for example, insulin);
- are required for emergency treatment, such as self-injectables that counteract allergic reactions.

An independent pharmacy benefits management (PBM) company, FutureScripts, 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. Independence Blue Cross 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.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.

FutureScripts, an OptumRX company, is an independent company that provides pharmacy benefit management services.

Independence

Independence

Vision

The clear solution to your vision care needs

Use your Vision benefits

Vision problems are among the most prevalent health issues in the United States. Nearly 176 million American adults wear some form of vision correction.* An eye exam can help prevent vision problems and help detect more serious chronic health conditions, such as diabetes, hypertension, and heart disease.

Your vision plan gives you access to timely treatment and covered services like refraction, glaucoma screenings, and dilation that will help paint a picture of your overall health.

View your benefits online

visit www.ibxpress.com

Freedom of provider choice

You have access to the Davis Vision provider network, which includes more than 57,000 ophthalmologists, optometrists, and regional and national retailers, including Visionworks.

Choose from an extensive frame collection

You can select any frame from the Davis Vision Exclusive Frame Collection of stylish, Contemporary frames covered in full, or with a minimal copay. You also have the freedom to use your frame allowance at any network location toward any frame on the market today. This includes Visionworks, which has over an average of 2,000 frames to to choose from per store.

The Davis Vision Exclusive Frame Collection features over 200 of the latest frames to mirror the fit, function, and fashion needs of today's vision care consumer. Every frame or lens purchased at a participating provider is backed by an unconditional one-year breakage warranty for repair or replacement.

Coverage for contacts and laser vision correction

You can purchase replacement contact lenses through DavisVisionContacts.com, a mail-order contact lens replacement program. Davis Vision Contacts will ship replacement contact lenses or solution anywhere the same day and you are guaranteed low prices.

If you're interested in Laser Vision Correction, you can receive up to *25 percent off* a participating provider's usual and customary fees, or *5 percent off* any participating provider's advertised specials on laser vision correction services.

You can also view your benefits online through ibxpress.com. You can:

- check eligibility;
- locate a participating provider;
- view the Davis Vision Collection of frames.

DAVIS VISION
EYECARE REFRAMED™

Visionworks retail centers offer affordability, choice, and convenience

Visionworks optical retail centers are a cornerstone of the provider network and support IBC's commitment to choice. Visionworks retail centers are located across the Philadelphia five-county area, surrounding counties, and states, making it convenient to find one close to you.

Visionworks has high-quality eyeglasses, designer frames, and a wide variety of contact lenses, reading glasses, and specialty lenses all at great prices. With a dedication to quality, durability, and variety, Visionworks provides you with all you need to find the right look. Visionworks also has one of the largest selections of fun and fashionable kid's eyeglasses in the eyewear industry. Kids 13 and younger receive free impact and scratch-resistant lenses.

Since you have IBC Vision Care benefits, you receive even more savings at Visionworks on items, such as:

- high-quality designer and exclusive brands frames;
- eyeglass lenses;
- contact lenses;
- sunglasses;
- vision correction.

To find a Visionworks near you, go to www.visionworks.com.

If you have any questions about your IBC Vision Care, call **1-800-ASK-BLUE** (TTY: 711).

*VisionWatch - The Vision Council Member Benefit Reports, The Vision Council & Jobson, 12ME September 2009

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.

IBC Vision Care is administered by Davis Vision, an independent company. An affiliate of Independence Blue Cross has a financial interest in Visionworks, a separate company.

REQUIRED OUTLINE OF COVERAGE
FOR
INDIVIDUAL HMO SUBSCRIBER AGREEMENT
issued by

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

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

A Pennsylvania corporation
Located at:
1901 Market Street
P.O. Box 7516
Philadelphia, PA 19103-7516

NOTICE OF SUBSCRIBER'S RIGHT TO EXAMINE AGREEMENT: The Subscriber shall have the right to return the Subscriber Agreement within ten (10) days of its delivery and to have the premium refunded if, after examination of the Subscriber Agreement, the Subscriber is not satisfied for any reason. This Agreement may be returned to: Keystone Health Plan East, Inc., 1901 Market Street, Philadelphia, PA 19103. If the Agreement is returned, it will be null and void from the beginning and no benefits will be payable under its terms.

OUTLINE OF COVERAGE

1. **Please read the Agreement carefully.** This outline provides a very brief description of the important features of the Agreement. This outline is not the HMO Agreement and only the actual HMO Subscriber Agreement provisions will control. The Agreement itself sets forth in detail the rights and obligations of both the Applicant and the HMO. It is, therefore, important to read the Agreement carefully!

2. **HMO Coverage.** This HMO Subscriber Agreement sets forth a comprehensive program of inpatient and outpatient health care benefits. In most cases, Members must obtain Referrals for Covered Services, and benefits are provided only for services performed by a Participating Provider. Preapproval by Keystone Health Plan East, Inc. is required for certain services, and a Referral from your Primary Care Provider is required for Specialist Services. Certain benefits are subject to cost-sharing provisions such as Copayments and/or Coinsurance.

THIS IS A NON-PARTICIPATING CONTRACT

3. A brief description of the benefits contained in the Agreement is as follows:

This HMO Coverage utilizes a Participating (In-Network) Provider Network. Except for Emergency Services, all services begin with your Primary Care Physician, the Participating Provider selected by you who is responsible for providing all primary care Covered Services and for authorizing and coordinating all covered Medical Care, including Referrals for Specialist Services.

All primary and specialist care services must be received from Participating (In-Network) Providers unless Preapproved by the HMO, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area.

Subject to the Exclusions, Copayment, Coinsurance, and Benefit Maximum amounts of the Agreement, you have access to Covered Services during a Benefit Period, as described in this section.

This coverage utilizes Preapproval and utilization management procedures, which must be followed in order for services to be considered for coverage.

The percentages for your Coinsurance and Allowed Amounts shown below are not always calculated on actual charges. For an explanation on how coinsurance is calculated, see the "Allowed Amount" definition below.

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

A. For services provided by a Participating Facility Provider, the term "Allowed Amount" is the HMO's fee schedule amount.
B. For services provided by a Participating Professional Provider, "Allowed Amount" is the HMO's fee schedule amount.
C. For services provided by Participating Ancillary Service Providers, "Allowed Amount" means the amount that the HMO has negotiated with the Participating Ancillary Service Provider as total reimbursement for the Covered Services.
D. For Pediatric Dental Covered Services provided by a Participating Dentist, Allowed Amount means the Maximum Allowable Charge (MAC) for the specific Pediatric Dental Covered Service. Participating Dentists accept contracted MACs as payment in full for Pediatric Dental Covered Services.

OUT-OF-POCKET MAXIMUM – the maximum dollar amount that a Member pays for Covered Services under this Subscriber Agreement in each Benefit Period as shown in Section SC-Schedule Of Cost Sharing & Limitations. The Out-of-Pocket Maximum includes Copayments and Coinsurance amounts; it does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Subscriber Agreement.

SECTION SC - SCHEDULE OF COST SHARING & LIMITATIONS

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

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

Your Primary Care Physician or Referred Specialist must obtain Preapproval from the HMO to confirm the HMO's coverage for certain Covered Services. If your Primary Care Physician or Referred Specialist provides a Covered Service or Referral without obtaining the HMO's Preapproval, you are not responsible for payment for that Covered Service. To access a complete list of services that require Preapproval, log onto the HMO website, at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

Benefit Period: Your Benefit Period is a Calendar Year (1/1 – 12/31).

OUT-OF-POCKET MAXIMUM	
Per Member	$4,000
Per Family	$8,000

The Out-of-Pocket Maximum is the maximum dollar amount that a Member pays for Covered Services within a Benefit Period. The Out-of-Pocket Maximum includes Copayments and Coinsurance amounts for Essential Health Benefits; it does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Subscriber Agreement.

LIFETIME BENEFIT MAXIMUM	Unlimited

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
OFFICE VISITS TO YOUR PCP (Non-Preventive) (Includes Retail Clinic Visits, Home Visits and Outpatient Consultations)	$15 per Provider, per date of service
OFFICE VISITS TO A SPECIALIST	$30 per Provider, per date of service
PEDIATRIC PREVENTIVE CARE	$0
IMMUNIZATIONS	$0
ADULT PREVENTIVE CARE **Routine/Preventive Colonoscopy** Providers that are not Hospital based Providers that are Hospital based*	$0 $0 $750 per procedure
Note for Routine/Preventive Colonoscopy: *The Hospital based Copayment will be waived if your Primary Care Physician determines that it would be medically inappropriate to have the preventive colonoscopy service provided in the ambulatory setting. There is no cost share applied if your preventive colonoscopy service is performed at a facility that is not Hospital based (for example, an Ambulatory Facility); if your preventive colonoscopy service is performed at a Hospital based facility, the Hospital based copayment shown above will apply.	
WOMEN'S PREVENTIVE HEALTH CARE (Includes Routine Gynecological Exam, Pap Smear, one (1) per Benefit Period, all ages)	$0
MAMMOGRAMS	$0
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT	$0
Six (6) Outpatient nutrition counseling visits/sessions per Benefit Period	
SMOKING CESSATION	$0
INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
HOSPITAL SERVICES*	$400 per day, up to maximum $2,000 per admission
MEDICAL CARE **Inpatient Professional Services**	$0
SKILLED NURSING CARE FACILITY*	$200 per day, up to maximum $1,000 per admission
Maximum of One hundred twenty (120) Inpatient days per Benefit Period.	

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
ALCOHOL OR DRUG ABUSE AND DEPENDENCY TREATMENT (including Detoxification)	
Inpatient Alcohol Or Drug Abuse And Dependency Treatment Admissions*	$400 per day, up to maximum $2,000 per admission
Outpatient Alcohol Or Drug Abuse And Dependency Treatment Service/Occurrence	$30 per Provider, per date of service
BLOOD	10% of the Allowed Amount
HOSPICE SERVICES	
Inpatient Hospice Services	$0
Outpatient Hospice Services	
Professional Service	$0
Facility Service for Respite Care	$0
Respite Care is provided for a maximum of seven (7) days every six (6) months.	
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES	
Artificial Insemination	$30 per Provider, per date of service
Maternity/Obstetrical Care	
Professional Service	$30, first visit only
Facility Services *	$400 per day, up to maximum $2,000 per admission
Elective Abortion	
Professional Service	$30 per Provider, per date of service
Outpatient Facility Services	
Ambulatory Surgical Facility	$100 per procedure
Outpatient Hospital-Based Facility	$300 per procedure

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES (continued)	
Newborn Care	$0
MENTAL HEALTH CARE **Inpatient Mental Health Care Admissions** *	$400 per day, up to maximum $2,000 per admission
Outpatient Mental Health Care Service/Occurrence	$30 per Provider, per date of service
SERIOUS MENTAL ILLNESS HEALTH CARE	
Inpatient Serious Mental Illness Health Care Admissions *	$400 per day, up to maximum $2,000 per admission
Outpatient Serious Mental Illness Health Care Service/Occurrence	$30 per Provider, per date of service
SURGICAL SERVICES **Inpatient Professional Services**	$0
Outpatient Facility Charges **Ambulatory Surgical Facility** **Outpatient Hospital-Based Facility**	 $100 per day $300 per day
Outpatient Anesthesia	$0
Voluntary Second Surgical Opinion	$30 per opinion
If more than one (1) surgical procedure is performed by the same Professional Provider during the same operative session, the HMO will pay 100% of the contracted fee schedule amount, less any required Member Copayments, for the highest paying procedure and 50% of the contracted fee schedule amount for each additional procedure.	

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
TRANSPLANT SERVICES	
Inpatient Transplant Services	$400 per day, up to maximum $2,000 per admission
Outpatient Transplant Services	$100 per procedure

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
AMBULANCE	
Emergency Transport	$50 per destination
Non-Emergency Transport	$100 per destination
DAY REHABILITATION PROGRAM	
Outpatient Visits Thirty (30) visits per Benefit Period	10% of the Allowed Amount
DENTAL, ACCIDENTAL INJURY	10% of the Allowed Amount
DIABETIC EDUCATION PROGRAM	$0
DIABETIC EQUIPMENT AND SUPPLIES	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
DIAGNOSTIC SERVICES	
Routine Radiology/Diagnostic Services (includes Allergy Testing)	$30 per date of service
Non-Routine Diagnostic Services (including MRI/MRA, CT/CTA scans, PET scans)	$60 per date of service

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
DIAGNOSTIC SERVICES (continued)	
Sleep Studies performed at Home and Freestanding Facility	$100 per date of service
Sleep Studies performed at Outpatient Hospital-Based Facility	$300 per date of service
DURABLE MEDICAL EQUIPMENT (including PROSTHETIC DEVICES and ORTHOTICS)	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
EMERGENCY CARE – Facility	$250 per service/ occurrence
The emergency room Copayment will be the PCP office visit Copayment if you notify us that you were directed to the emergency room by your Primary Care Physician or the HMO, and the services could have been provided in your Primary Care Physician's office.	
HABILITATIVE SERVICES	
Physical/Occupational Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
Speech Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
HOME HEALTH CARE	10% of Allowed Amount
Maximum of Sixty (60) visits per Benefit Period. Special or Private Duty Nursing Not Included.	
INJECTABLE MEDICATIONS	
Standard Injectable Drugs	$0
Specialty Drugs	$60 per visit
LABORATORY AND PATHOLOGY TESTS	$0

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
MEDICAL CARE **Outpatient Professional Services**	$0
MEDICAL FOODS AND NUTRITIONAL FORMULAS	10% of the Allowed Amount
REHABILITATIVE SERVICES	
Physical Therapy/Occupational Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
There is no visit limit for lymphedema therapy related to a mastectomy.	
Speech Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
SPINAL MANIPULATION THERAPY	$50 per Provider, per date of service
Twenty (20) visits per Benefit Period	
THERAPY SERVICES **Cardiac Rehabilitation Therapy** Thirty-six (36) visits per Benefit Period	$30 per Provider, per date of service
Chemotherapy	$30 per Provider, per date of service
Dialysis	$30 per Provider, per date of service
Infusion Therapy	$30 per Provider, per date of service
Pulmonary Rehabilitation Therapy Thirty-six (36) visits per Benefit Period	$30 per Provider, per date of service
Radiation Therapy	$30 per Provider, per date of service
Respiratory Therapy	$30 per Provider, per date of service

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
URGENT CARE CENTER - Facility	$100 per Provider, per date of service

BENEFIT	FOR BENEFITS PROVIDED BY MDLIVE®:
Telemedicine Services Provided by MDLIVE®	$40 fee per Provider per date of service

Inpatient Copayment Waiver Provision
*The Inpatient Copayment as stated in this Schedule applies to each admission, readmission or transfer of a Member for Covered Services for Inpatient treatment of any condition. For purposes of calculating the total Copayment due, any admission occurring within ten (10) days of discharge from any previous admission shall be treated as part of the previous admission.

PRESCRIPTION DRUG COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Participating Retail Pharmacy	
Generic Drug	$5
Preferred Brand Drug	$40
Non-Preferred Drug	$70
Specialty Drug	50% for Covered Drugs or Supplies up to a Prescription Cost Sharing Maximum (member cost share maximum) of $700

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Participating Mail Service Pharmacy	
The amount of your cost sharing is determined by the days-supply you receive of a Covered Maintenance Drug:	
For a 1-30 days-supply:	
Generic Drug	$5
Preferred Brand Drug	$40
Non-Preferred Drug	$70
For a 31-90 days-supply:	
Generic Drug	$10
Preferred Brand Drug	$80
Non-Preferred Drug	$140
Non-Participating Pharmacy	Member pays 70% of Allowed Amount for Covered Drugs or Supplies.

PRESCRIPTION DRUG COST SHARING & LIMITATIONS
(continued)

PRESCRIPTION DRUG LIMITATIONS

A description of limitations for your Covered Drugs Or Supplies is described below:

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

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

   Up to a ninety (90) day supply of a Maintenance Prescription Drug may be obtained through a Participating Mail Service Pharmacy**.**

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

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

5. Members must present their Identification Card, and the existence of Prescription Drug coverage must be indicated on the card.

6. A Member shall pay to a Participating Pharmacy:

   A. One hundred percent (100%) of the cost for a Prescription Drug dispensed when the Member fails to show his or her Identification Card. A claim for reimbursement for Covered Drugs Or Supplies may be submitted to the HMO; or
   B. One hundred percent (100%) of a non-Covered Drug or Supply; or
   C. The applicable Prescription Drug cost sharing.

7. In certain cases the HMO may determine that the use of certain Covered Drugs or Supplies for a Member’s medical condition requires prior authorization for Medical Necessity.

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

Note for Prescription Drug shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained at a Participating Pharmacy or a Participating Mail Service Pharmacy for generic products and for certain brand products when a generic alternative or equivalent to the brand product does not exist. All other Brand contraceptive products are covered at standard cost-sharing as reflected in this Section SC - Schedule of Cost Sharing & Limitations.

PEDIATRIC VISION COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATIONS**
VISION CARE	
Participating Provider	
Routine Eye Exam & Refraction	$0 Once every Benefit Period
Frames and Prescription Lenses	$0 Once every Benefit Period
Elective Contact Lenses (in lieu of eyeglasses)	$0, at participating independent providers for Davis collection contacts
Elective Contact Lenses Fitting and Follow-up Care	15% discount, not available at all Participating Providers.
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	$0
Non-Participating Provider	Not Covered

PEDIATRIC DENTAL COST SHARING & LIMITATIONS	
DENTAL DEDUCTIBLE: $50 per eligible Member must be met before applicable Coinsurance amounts are applied, unless noted otherwise below.	
BENEFIT	**COST SHARING/LIMITATIONS**
Oral Evaluations (Exams)	0% Dental deductible does not apply
Radiographs (All X-Rays)	50% Dental deductible does not apply
Prophylaxis (Cleanings)	0% Dental deductible does not apply
Fluoride Treatments	0% Dental deductible does not apply
Palliative Treatment (Emergency)	50% Dental deductible does not apply
Sealants	0% Dental deductible does not apply

PEDIATRIC DENTAL COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATIONS**
Other Diagnostic & Preventive Services	Not Covered
Space Maintainers	50%
Amalgam Restorations (Metal fillings)	50%
Resin-based Composite Restorations (White fillings)	50%
Crowns, Inlays, Onlays	50%
Crown Repair	50%
Endodontic Therapy (Root canals, etc.)	50%
Other Endodontic Services	50%
Surgical Periodontics	50%
Non-Surgical Periodontics	50%
Periodontal Maintenance	50%
Prosthetics (Complete or Fixed Partial Dentures)	50%
Adjustments and Repairs of Prosthetics	50%
Other Prosthetic Services	50%
Maxillofacial Prosthetics	Not Covered
Implant Services	50%
Simple Extractions	50%
Surgical Extractions	50%
Oral Surgery	50%
General Anesthesia, Nitrous Oxide and/or IV Sedation	50%
Consultations	0% Dental deductible does not apply
Adjunctive General Services	Not Covered
Medically Necessary Orthodontics*, with the HMO's prior approval and a written plan of care	50%

*There is a 12 month Waiting Period applicable to Medically Necessary Orthodontics

Note For Waiting Period:
The waiting period for certain benefits to be payable under this plan will not be satisfied until twelve (12) months of the contract year have expired and a renewal of the plan will be necessary to fairly access the benefits.

PEDIATRIC DENTAL LIMITATIONS:

Covered Services are limited as detailed below. For Covered Services listed below that apply an age limitation, those services are covered until 12:01 a.m. of the birthday when the patient reaches the age as stated.

All benefits under this plan end at the end of the calendar year in which the child turns age 19.

1. Full mouth x-rays – one (1) every five (5) year(s).

2. Bitewing x-rays – one (1) set(s) per six (6) months.

3. Oral Evaluations:

- Comprehensive, periodic and limited problem focused – one (1) of these services per six (6) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
- Consultations – one (1) of these services per Dentist per patient per twelve (12) months for a consultant other than a Pedodontist or Orthodontist.
- Detailed problem focused – one (1) per Dentist per patient per twelve (12) months per eligible diagnosis.

4. Prophylaxis – one (1) per six (6) months. One (1) additional for Members under the care of a medical professional during pregnancy.

5. Topical fluoride treatment – two (2) per twelve (12) months.

6. Fluoride varnish – two (2) per twelve (12) months.

7. Space maintainers – one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

8. Sealants – one (1) per tooth per 36 months.

9. Preventive resin restorations – one (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.

10. Prefabricated stainless steel crowns – one (1) per tooth per 36 months.

11. Periodontal Services:

- Full mouth debridement – one (1) per lifetime.
- Periodontal maintenance following active periodontal therapy – four (4) per twelve (12) months in addition to routine prophylaxis.
- Periodontal scaling and root – one (1) per twenty-four (24) months per area of the mouth.
- Surgical periodontal procedures – one (1) per thirty-six (36) months per area of the mouth.
- Guided tissue regeneration – one (1) per tooth per lifetime.

12. Replacement of restorative services only when they are not, and cannot be made, serviceable:

- Basic restorations – not within twenty-four (24) months of previous placement.
- Single crowns, inlays, onlays – not within five (5) years of previous placement.
- Buildups and post and cores – not within five (5) years of previous placement.
- Replacement of natural tooth/teeth in an arch – not within five (5) years of a fixed partial denture, full denture or partial removable denture.

13. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

14. Pulpal therapy – one (1) per eligible tooth per lifetime. Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

15. Root canal retreatment – one (1) per tooth per lifetime.

16. Recementation – one (1) per five (5) years. Recementation during the first twelve (12) months

following insertion by the same Dentist is included in the prosthetic service benefit.

17. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

18. Therapeutic drug injections – only covered in unusual circumstances, by report.

19. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

20. Payment for orthodontic services shall cease at the end of the month after termination by the HMO.

Medically Necessary Orthodontics Coverage:

In this section, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician or Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with the generally accepted standards of medical/dental practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient or physician/Dentist, 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.

As used in subpart 1, above, "generally accepted standards of medical/dental practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- recognized Medical/Dental and Specialty Society recommendations;
- the views of physicians/Dentists practicing in the relevant clinical area; and
- any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

Coverage of Medically Necessary Orthodontics:

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the Member's teeth or their supporting structures and,
   b) Restoring the Member's oral structure to health and function.

2. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services.

3. All Medically Necessary orthodontic services require prior approval and a written plan of care.

Predetermination

A predetermination is a request for the HMO to estimate benefits for a dental treatment the Member has not yet received. In a predetermination review, the HMO looks at patient eligibility, Dental Necessity and the Agreement's coverage for the treatment. Predetermination is not required for any benefits under the Agreement. Payment of benefits for a predetermined service is subject to the Member's continued eligibility in the Agreement. At the time the claim is paid, the HMO may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with the Member's current Agreement and Out-of-Pocket Maximums on the date of service.

Review of a Benefit Determination

If the Member is not satisfied with a benefit determination or payment, the Member should contact the HMO's Customer Service Department at the toll-free telephone number on their ID card. If, after speaking with a Customer Service representative, the Member is still dissatisfied, refer to the Resolving Problems section of this Agreement for further steps the Member can take regarding their claim.

4. The Contract is subject to a number of exclusions, conditions and limitations. These include the following:

The following are excluded from your coverage:

1. Services, supplies or charges which are:
   A. Not provided by or Referred by the Member's Primary Care Physician except in an Emergency; or as specified elsewhere in this Agreement;
   B. Not Medically Necessary, as determined by the Primary Care Physician or Referred Specialist or the HMO, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under this Subscriber Agreement; or
   C. Provided by family members, relatives and friends.

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

3. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;

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

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

6. Services, supplies or charges paid or payable by Medicare when Medicare is primary. For purposes of this Subscriber Agreement, a service, supply or charge is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premiums for, maintains, claims or receives Medicare benefits.

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

8. For Members age nineteen (19) and older, dental services and devices related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this Subscriber Agreement. Services not covered include, but are not limited to: apicoectomy (dental root resection); prophylaxis of any kind; root canal treatments; soft tissue impactions; alveolectomy; bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise described in this Subscriber Agreement;
   A. For dental implants for any reason;
   B. For dentures, unless for the initial treatment of an Accidental Injury or trauma;
   C. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
   D. For oral devices used for temporomandibular joint syndrome or dysfunction;
   E. For injury as a result of chewing or biting (neither is considered an Accidental Injury);

9. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a Prescribed Plan of Treatment;

10. Services or supplies which are Experimental/Investigative in nature, except Routine Patient Costs Associated With Qualifying Clinical Trials that meet the definition of a Qualifying Clinical Trial under this Agreement, and which have been Preapproved by the HMO.

    Routine patient costs do not include any of the following:
    A. the investigational item, device, or service, itself;
    B. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    C. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

11. Routine physical examinations for non-preventive purposes, such as pre-marital examinations physicals for college, camp or travel; and examinations for insurance, licensing and employment;

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

13. Cosmetic Surgery, including cosmetic dental Surgery. Cosmetic Surgery is defined as any Surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected.

    This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to, the ears, lips, chin, jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

    This exclusion does not include those services performed when the patient is a Member of the HMO and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process.

    This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities for children;

14. Any Therapy Service provided for: ongoing outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond the plan's day limits, if any, shown on Section SC - Schedule Of Cost Sharing & Limitations; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;

15. Vision care including, but not limited to:
    A. All surgical procedures performed solely to eliminate the need for or reduce the Prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty;
    B. For Members age nineteen (19) and older, any eyeglasses, lenses or contact lenses and the vision examination for Prescribing or fitting eyeglasses or contact lenses except as otherwise described in this Subscriber Agreement; and
    C. Lenses which do not require a Prescription;
    D. Any lens customization such as, but not limited to tinting, oversize or progressive lenses; antireflective coatings, U-V lenses or coatings, scratch resistant coatings, mirror coatings, or polarization;
    E. Deluxe frames; or
    F. Eyeglass accessories such as cases, cleaning solution and equipment.

16. Any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Developmental Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or intellectual disability; or treatment or care to effect environmental or social change;

17. Immunizations required for employment purposes or travel. This exclusion does not apply to travel immunizations required by ACIP.

18. Custodial and Domiciliary Care, residential care, protective and supportive care, including educational services, rest cures and convalescent care;

19. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary. This exclusion does not apply to the HMO's weight reduction program or nutrition counseling visits/sessions as described in the Nutrition Counseling for Weight Management provision in this Agreement;

20. For appetite suppressants;

21. For oral non-elemental nutritional supplements (e.g. Boost, Ensure, PediaSure), casein hydrolyzed formulas (e.g. Nutramigen, Alimentum, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, soy-based products. 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;

22. For elemental semi-solid foods (e.g. Neocate Nutra);

23. For products that replace fluids and electrolytes (e.g. Electrolyte Gastro, Pedialyte)

24. For additives (e.g. Duocal, fiber, or vitamins) and food thickeners (e.g. Thick-It, Resource ThickenUp);

25. For supplies associated with the oral administration of formula (e.g. bottles, nipples).

26. Customized wheelchairs;

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

28. Routine foot care as defined in the HMO's medical policy, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

29. Marriage or religious counseling;

30. For the Maintenance of chronic conditions, illness or injury;

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

32. Ambulance service, unless Medically Necessary and as provided in the subsection entitled "Ambulance" specified in Section CS – Description of Covered Services of this Agreement;

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

34. Charges for completion of any insurance form;

35. For Prescription Drugs and medications, except as provided under the Prescription Drug Benefit described in this Agreement;

36. For Contraceptives, except as covered under the Prescription Drug Benefit described in this Agreement;

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

38. For over-the-counter drugs, or any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient Stay;

39. The following outpatient services that are not performed by your Primary Care Physician's Designated Provider, when required under the HMO plan, unless Preapproved by the HMO: (a) Rehabilitation Therapy Services (other than Speech Therapy); (b) diagnostic radiology services for Members age five (5) or older; and (c) laboratory and pathology tests;

40. For Cognitive Rehabilitative Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (For example: stroke, acute brain insult, encephalopathy);

41. Inpatient or Outpatient Care Private Duty Nursing services;

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

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

    This exclusion does not apply to Self- Administered Prescription Drugs that are:
    - Covered under Section RX - Prescription Drugs;
    - 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 benefit or free-standing prescription drug contract issued by the HMO or its affiliates; or
    - Required for treatment of an Emergency condition that requires a Self- Administered Prescription Drug.

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

45. Services Incurred prior to the Effective Date of Coverage;

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

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

48. Charges not billed and performed by a Provider;

49. Services performed by a Professional Provider enrolled in an educational or training program when such services are related to the educational or training program and are provided through a hospital or university;

50. For treatment of obesity, including for surgical treatment of obesity. This includes, but is not limited to: (a) weight management programs, (b) dietary aids, supplements, injections and medications (c) weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician (d) group nutrition counseling.

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

51. Charges in excess of benefit maximums;

52. Counseling with patient's relatives except as may be specifically provided in the subsection entitled "Treatment of Alcohol Or Drug Abuse And Dependency" or "Transplant Services" specified in Section CS – Description of Covered Services of this Agreement;

53. For sex therapy or other forms of counseling for treatment of sexual dysfunction;

54. With regard to Durable Medical Equipment (DME), equipment for which any of the following statements are true is not DME and will not be covered. Any item:
    A. That is for comfort or convenience. Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps; telephone alert systems; bed-wetting alarms; and ramps.
    B. That is inappropriate for home use. This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes.
    C. That is a non-reusable supply or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not covered include, but are not limited to: incontinence pads; lamb's wool pads; ace bandages; catheters (non-urinary); face masks (surgical); disposable gloves, sheets and bags; and irrigating kits.
    D. That is not primarily medical in nature. Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to: ear plugs; exercise equipment; ice pack; speech teaching machines; strollers; silverware/utensils; feeding chairs;

toileting systems; toilet seats; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.

E. That has features of a medical nature which are not required by the patient's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.
F. That duplicates or supplements existing equipment for use when traveling or for an additional residence. For example, a patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would not be eligible for two identical items, or one for each living space.
G. Which is not customarily billed for by the Provider. Items not covered include, but are not limited to: delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.
H. That modifies vehicles, dwellings, and other structures. This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability or (ii) any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
I. 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.
J. That is for environmental control. Items not covered include, but are not limited to: air cleaners; air conditioners; dehumidifiers; portable room heaters; and ambient heating and cooling equipment.

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

55. For Skilled Nursing Facility benefits:
    A. When confinement is intended solely to assist a Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
    B. For the treatment of Alcohol Or Drug Abuse And Dependency and Mental Illness Health Care; or
    C. After the Member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care.

56. For Hospice Care benefits for the following:
    A. Private Duty Nursing care;
    B. Research studies directed to life lengthening methods of treatment;
    C. Expenses Incurred in regard to the Member's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property); or
    D. Treatment to cure the Member's illness.

57. With regard to Home Health Care services and supplies in connection with home health services for the following:
    A. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
    B. Rental or purchase of Durable Medical Equipment;
    C. Rental or purchase of medical appliances (e.g., braces) and Prosthetic Devices (e.g., artificial limbs); supportive environmental materials and equipment, such as

handrails, ramps, telephones, air conditioners and similar services, appliances and devices;

D. Prescription Drugs;
E. Provided by family members, relatives, and friends;
F. A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
G. Emergency or non-emergency ambulance services;
H. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
I. Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
J. Visits by any Provider personnel solely for the purpose of assessing a Member's condition and determining whether or not the Member requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

58. For home blood pressure machines, except for Members: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, (c) with end-stage renal disease receiving home Dialysis, or (d) who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates;

59. Any services, supplies or treatments not specifically listed in this Agreement as covered benefits, unless the unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health. The HMO reserves the right to specify Providers of, or means of delivery of Covered Services, supplies or treatments under this plan, and to substitute such Providers or sources where medically appropriate;

60. Hearing or audiometric examinations, and Hearing Aids, including cochlear electromagnetic hearing devices and the fitting thereof. and, routine hearing examinations; Services and supplies related to these items are not covered;

61. Foot orthotic devices except as described in this Subscriber Agreement. This exclusion does not apply to foot orthotic devices used for the treatment of diabetes;

62. Wigs and other items intended to replace hair loss due to male/female pattern baldness; or due to illness or injury including but not limited to injury due to traumatic or surgical scalp avulsion, burns, or Chemotherapy;

63. For assisted fertilization techniques such as, but not limited to, in vitro fertilization; embryo transplant; ovum retrieval, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any services required in connection with these procedures;

64. Services for repairs or replacements of Prosthetic Devices or Durable Medical Equipment needed because the item was abused, lost or misplaced;

65. For Alternative Therapies/Complementary Medicine, including but not limited to: acupuncture; music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; rolfing; psychodrama; vitamin or other dietary supplements and therapy; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; and sleep therapy;

66. For services, supplies or charges a Member is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Member;

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

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

69. Charges for Orthoptic/Pleoptic Therapy;

70. The following exclusions apply to your **Prescription Drug benefits**:
    A. Devices of any type, even though such devices may require a Prescription Order. This includes, but is not limited to, therapeutic devices or appliances, hypodermic needles, syringes or similar devices, support garments or other devices, regardless of their intended use, except as specified as a benefit in your Subscriber Agreement. This exclusion does not apply to (a) devices used for the treatment or Maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and (b) devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines; or (c) Contraceptive devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
    B. Drugs Prescribed and administered in the Physician's office;
    C. Drugs which do not by federal or state law require a Prescription Order (i.e., over-the-counter) or drugs that require a Prescription Order but have an over-the-counter equivalent, except insulin, over-the counter drugs that are Prescribed by a Physician in accordance with applicable law, and drugs specifically designated by the HMO, whether or not Prescribed by a Physician.
    D. Any drugs covered under another provision of the Agreement;
    E. Prescription Drugs covered without charge under federal, state or local programs including Worker's Compensation and Occupational Disease laws;
    F. Medication for a Member confined to a rest home, Skilled Nursing Facility, sanitarium, extended care facility, Hospital or similar entity;
    G. Medication furnished by any other medical service for which no charge is made to the Member;
    H. Any Covered Drug or Supply administered at the time and place of the Prescription Order;
    I. Any charges for the administration of Prescription Legend Drugs or injectable insulin;
    J. Prescription Drugs provided by Non-Participating Pharmacies, except as specified in Section RX-Prescription Drug Benefits;
    K. Prescription Refills resulting from loss or theft, or any unauthorized Refills;
    L. Immunization agents, biological sera, blood or plasma, or allergy serum;
    M. Experimental or Investigational Drugs or drugs Prescribed for experimental (non-FDA approved) indications;
    N. Drugs used for cosmetic purposes, including but not limited to, anabolic steroids, minoxidil lotion, and Retin A (tretinoin), when used for non-acne related conditions. However, this exclusion does not include drugs Prescribed to treat medically diagnosed congenital defects and birth abnormalities;
    O. Pharmacological therapy for weight reduction or diet agents, unless Preapproved by

the HMO;

P. Injectable drugs, including injectable drugs used for the primary purpose of treating infertility or injectable drugs for fertilization. This exclusion does not include injectable Contraceptive Drugs;
Q. Prescription Drugs not approved by the HMO or Prescribed drug amounts exceeding the quantity level limits as conveyed by the FDA or the HMO's Pharmacy and Therapeutics Committee;
R. Specialty Drugs that are not purchased through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program. This exclusion does not apply to Insulin;
S. Any charge where the usual and customary charge is less than the Member's cost-sharing amount.

71. The following Exclusions apply to your **Pediatric Dental benefits**:

Only American Dental Association procedure codes are covered. **Except as specifically provided in this Agreement, no coverage will be provided for services, supplies or charges that are:**

A. Incurred prior to the Subscriber's Effective Date of Coverage or after the Termination Date of coverage under the Individual Agreement.
B. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
C. For prescription and non-prescription drugs, vitamins or dietary supplements.
D. Cosmetic in nature as determined by the HMO (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
E. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
F. For congenital mouth malformations or skeletal imbalances (for example but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion shall not apply to newly born children of Subscribers including newly adoptive children, regardless of age.
G. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Agreement. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
H. For treatment of fractures and dislocations of the jaw.
I. For treatment of malignancies or neoplasms.
J. For services and/or appliances that alter the vertical dimension (for example but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
K. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
L. For periodontal splinting of teeth by any method.
M. For duplicate dentures, Prosthetic Devices or any other duplicative device.
N. For which in the absence of insurance the Member would Incur no charge.
O. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
P. For treatment and appliances for bruxism (night grinding of teeth).
Q. For any claims submitted to the HMO by the Member or on behalf of the Member in

excess of twelve (12) months after the date of service.

R. For incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).
S. For procedures that are:
   - part of a service but are reported as separate services; or
   - reported in a treatment sequence that is not appropriate; or
   - misreported or that represent a procedure other than the one reported.
T. For specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).
U. Fees for broken appointments.
V. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the HMO will apply.
W. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by the HMO.
   Orthodontic services for the following are excluded:
   - Treatments that are primarily for Cosmetic reasons;
   - Treatments for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment)
   - Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under Section SC – Schedule of Cost Sharing & Limitations. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

72. Any Mental Health Care, Serious Mental Illness Health Care, or Alcohol Or Drug Abuse And Dependency treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as Alternative Therapies/Complementary Medicine and obesity control therapy.

73. Non-medical services, such as vocational rehabilitation or employment counseling, for the treatment of Alcohol Or Drug Abuse And Dependency in an acute care Hospital.

5. GUARANTEED RENEWABLE:

Upon the payment of the applicable rate, the HMO agrees to make payment for those services as set forth in this Subscriber Agreement. Subject to the right of the HMO to terminate coverage in accordance with **Section EL – Eligibility, Change And Termination Rules Under The Plan**, this Agreement is guaranteed renewable and may be renewed by payment of renewal premiums within thirty (30) days after the first day of the month for which payment must be made. Coverage continues for a further period of twelve (12) consecutive months from the Anniversary Date of the Agreement, which is January 1, and annually thereafter, until terminated as provided in **Section EL – Eligibility, Change And Termination Rules Under The Plan**. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement. Subject to the approval of the Pennsylvania Insurance Department, the HMO may adjust premium rates. Any change in the premium rate shall become applicable for Subscribers upon the expiration of the period covered by the Subscriber's current payment at the time of such change.

6. For purposes of the provisions of the Patient Protection and Affordable Care Act with respect to the Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions the Policy Year for this Agreement will be a Calendar Year.

INDIVIDUAL HMO SUBSCRIBER AGREEMENT
Guaranteed Renewable

Issued by

KEYSTONE HEALTH PLAN EAST, INC.*

("Keystone" or "the HMO")

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

A Pennsylvania corporation
Located at:
1901 Market Street
P.O. Box 7516
Philadelphia, PA 19103-7516

DESCRIPTION OF COVERAGE:
This HMO Subscriber Agreement sets forth a comprehensive program of inpatient and outpatient health care benefits. In most cases, Members must obtain Referrals for Covered Services, and benefits are provided only for services performed by a Participating Provider. Preapproval by Keystone Health Plan East, Inc. is required for any service requiring a Referral to a Provider who is not a Participating Provider. Certain benefits are subject to cost-sharing provisions such as Copayments and/or Coinsurance.

NOTICE OF SUBSCRIBER'S RIGHT TO EXAMINE AGREEMENT: The Subscriber shall have the right to return the Subscriber Agreement within ten (10) days of its delivery and to have the premium refunded if, after examination of the Subscriber Agreement, the Subscriber is not satisfied for any reason. This Agreement may be returned to: Keystone Health Plan East, Inc., 1901 Market Street, Philadelphia, PA 19103. If the Agreement is returned, it will be null and void from the beginning and no benefits will be payable under its terms.

GUARANTEED RENEWABLE: Upon the payment of the applicable rate, the HMO agrees to make payment for those services as set forth in this Subscriber Agreement. Subject to the right of the HMO to terminate coverage in accordance with Section EL – Eligibility, Change And Termination Rules Under The Plan, this Agreement is guaranteed renewable and may be renewed by payment of renewal premiums within thirty (30) days after the first day of the month for which payment must be made. Coverage continues for a further period of twelve (12) consecutive months from the Anniversary Date of the Agreement, which is January 1, and annually thereafter, until terminated as provided in Section EL – Eligibility, Change And Termination Rules Under The Plan. Non-renewal shall not be based on the deterioration of mental or physical health of any individual covered under this Agreement. Subject to the approval of the Pennsylvania Insurance Department, the HMO may adjust premium rates. Any change in the premium rate shall become applicable for Subscribers upon the expiration of the period covered by the Subscriber's current payment at the time of such change.

THIS IS A NON-PARTICIPATING CONTRACT

KEYSTONE HEALTH PLAN EAST, INC.

Paula Sunshine

Paula Sunshine
SVP and Chief Marketing Executive

KE 650 IND FC EXC-OFF **Platinum**
Rev. 1/17 **HMO 50**

Language Access Services

If you, or someone you're helping, has questions about Keystone Health Plan East, Inc., you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-275-2583 TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Keystone Health Plan East, Inc., tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-275-2583 TTY 711.

如对 Keystone Health Plan East, Inc. 有任何问题，请您或您所帮助的人联系我们提供的免费多语言信息服务。翻译服务请拨打 1-800-275-2583。

Nếu quý vị hoặc người mà quý vị đang trợ giúp có câu hỏi về Keystone Health Plan East, Inc., quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để yêu cầu thông dịch viên, hãy gọi số 1-800-275-2583.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу программы Keystone Health Plan East, Inc., то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-275-2583.

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Keystone Health Plan East, Inc., hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-275-2583 uffrufe.

Keystone Health Plan East, Inc. 와 관련하여 궁금한 사항이 있으신 경우, 귀하 또는 귀하의 지원을 받는 사람은 관련 정보 및 지원을 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-800-275-2583 로 전화해 주십시오.

Se tu o qualcuno che stai aiutando avete domande su Keystone Health Plan East, Inc., hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, puoi chiamare il numero 1-800-275-2583.

إذا كان لديك أو لدى شخص تساعده أسئلة بخصوص Keystone Health Plan East, Inc.، فلديك الحق في الحصول على المعلومات الضرورية بلغتك دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-800-275-2583.

Si vous, ou quelqu'un que vous aidez, a des questions à propos de Keystone Health Plan East, Inc., vous avez le droit d'obtenir gratuitement de l'aide et l'information dans votre langue. Pour parler à un interprète, appelez 1-800-275-2583.

Wenn Sie selbst oder eine Person, der Sie helfen, Fragen über Keystone Health Plan East, Inc. haben, so haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache anzufordern. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-275-2583 an.

જો તમને અથવા તમે કોઇને મદદ કરી રહ્યા તેમાંથી કોઇને Keystone Health Plan East, Inc. વિશે પ્રશ્નો હોય, તો તમને મદદ અને માહિતી તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, આ 1-800-275-2583 પર કોલ કરો.

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie do programu Keystone Health Plan East, Inc., mogą Państwo uzyskać bezpłatną informację i pomoc w Waszym języku. Aby porozmawiać z tłumaczem, proszę zadzwonić pod numer 1-800-275-2583.

Si ou menm, oswa yon moun w ap ede, gen kesyon konsènan Keystone Health Plan East, Inc., ou gen dwa pou resevwa èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-800-275-2583.

បើអ្នក ឬក៏នរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Keystone Health Plan East, Inc. អ្នកមានសិទ្ធិក្នុងការទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នក ដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅទូរសព្ទទៅលេខ 1-800-275-2583។.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Keystone Health Plan East, Inc., você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-275-2583.

Díí kwe'é atah nílínígíí Keystone Health Plan East, Inc. haada yit'éego bína ídíłkidgo éi doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídíłkidgo bee ná ahóót'i'díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą́ doo bą́ą́h ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnih 1-800-275-2583.

Kung ikaw, o ang taong iyong tinutulungan, ay may mga katanungan tungkol sa Keystone Health Plan East, Inc., may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa 1-800-275-2583.

ご本人やお客様の周りの人が Keystone Health Plan East, Inc. についてご質問などがある場合、無料でご希望の言語でのサポートや情報を入手することができます。インタプリタをご利用する方は、1-800-275-2583 までお電話ください。

اگر شما یا شخصی که به وی کمک می کنید، در رابطه با Keystone Health Plan East, Inc. سوالی دارید، این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. جهت گفتگو با یک مترجم، با شماره 1-800-275-2583 تماس حاصل فرمایید.

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

Keystone Health Plan East, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Keystone Health Plan East, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Keystone Health Plan East, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator. If you believe that Keystone Health Plan East, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have five ways to file a grievance:

- In person or by mail :
  Keystone Health Plan East, Inc.
  ATTN: Civil Rights Coordinator
  1901 Market Street
  Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY 711)
- By fax: 215-761-0245
- By email: civilrightscoordinator@ibx.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

TABLE OF CONTENTS

REQUIRED DISCLOSURE OF INFORMATION

WELCOME

Your ID Card

SECTION DE - DEFINITIONS

SECTION MC - USING THE HMO SYSTEM

Your Primary Care Physician
When You Need Care From a Specialist
Immediate Care
Continuing Care
Preapproval
Participating Providers
Changing Your Primary Care Physician
Designated Providers
Medical Technology Assessment
Prescription Drugs under the Plan
Disease Management and Decision Support Program
Utilization Management

SECTION ACC - ACCESS TO PRIMARY, SPECIALIST AND HOSPITAL CARE

Direct Access to Certain Care
Selection of a Primary Care Physician
How to Obtain A Specialist Referral
How to Obtain a Standing Referral
Designating a Referred Specialist as Your Primary Care Physician
Changing Your Primary Care Physician
Changing Your Referred Specialist
Provider Directory
Continuity of Care
Preapproval for Non-Participating Providers
Hospital Admissions
Recommended Plan of Treatment
Special Circumstances
Member Liability
Right To Recover Payments Made In Error

SECTION ER - EMERGENCY, URGENT CARE, FOLLOW-UP CARE

What are Emergency Services?
Medical Screening Evaluation
What is Urgent Care?
What is Follow-Up Care?
Urgent Care and Follow-Up Care Outside Keystone's Service Area –
The BlueCard Program
Continuing Care
Auto or Work-related Accidents

SECTION GM – AWAY FROM HOME CARE PROGRAM® GUEST MEMBERSHIP BENEFITS

Traveling Outside the HMO's Service Area for Longer Periods –

The Away From Home Care Program Guest Membership Benefits
When You Don't Use the BlueCard or Away From Home Care Guest Membership Programs
SECTION MR – YOUR MEMBERSHIP RIGHTS AND RESPONSIBILITIES
SECTION APP - COMPLAINT AND GRIEVANCE APPEAL PROCESS
SECTION COB - COORDINATION OF BENEFITS
Subrogation
SECTION CON - CONVERSION
SECTION PR - ADDITIONAL INFORMATION ABOUT HOW WE REIMBURSE PROVIDERS
SECTION CL - CLAIM PROCEDURES
Notice of Claim
Proof of Loss
Claim Forms
Submission of Claim Forms
Timely Payment of Claims
Physical Examinations and Autopsy
Payment of Claims
SECTION EL - ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THE PLAN
Eligibility
Records and Changes of Member Eligibility
Effective Date of Coverage
Termination of Coverage
Obligations on Termination of the Agreement
SECTION CS - DESCRIPTION OF COVERED SERVICES
Primary and Preventive Care
Inpatient Covered Services
Inpatient/Outpatient Covered Servioces
Outpatient Covered Servcies
SECTION RX – PRESCRIPTION DRUG BENEFITS
SECTION VS – PEDIATRIC VISION BENEFITS
SECTION DN – PEDIATRIC DENTAL BENEFITS
SECTION EX – EXCLUSIONS
SECTION GP – GENERAL PROVISIONS
Benefit Provisions
Clerical Error
Entire Agreement and Changes
Gender
Grace Period
Interpretation of Subscriber Agreement
Modification
Out-of-Area Services
Policies and Procedures
Premium Rate and Benefit Provisions
Premium Rate Changes
Prescription Drug Rebate Disclosure

Reinstatement
Relationship to Blue Cross and Blue Shield Plans
Status Change
Time Limit on Certain Defenses
SECTION SC - SCHEDULE OF COST SHARING & LIMITATIONS
PREVENTIVE SCHEDULE

REQUIRED DISCLOSURE OF INFORMATION

State law requires that the HMO make the following information available to you when you make a request in writing to the HMO.

A. A list of the names, business addresses and official positions of the membership of the Board of Directors or Officers of the HMO.
B. The procedures adopted to protect the confidentiality of medical records and other enrollee information.
C. A description of the credentialing process for health care Providers.
D. A list of the participating health care Providers affiliated with Participating Hospitals.
E. Whether a specifically identified drug is included or excluded from coverage.
F. A description of the process by which a health care Provider can Prescribe any of the following when either: (1) the Drug Formulary's equivalent has been ineffective in the treatment of the enrollee's disease; or (2) the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.

1. Specific drugs;
2. Drugs used for an off-label purpose; and
3. Biologicals and medications not included in the Drug Formulary for Prescription Drugs or biologicals.

G. A description of the procedures followed by the HMO to make decisions about the experimental nature of individual drugs, medical devices or treatments.
H. A summary of the methodologies used by the HMO to reimburse for health care services. (This does not mean that the HMO is required to disclose individual contracts or the specific details of financial arrangements we have with health care Providers).
I. A description of the procedures used in the HMO's quality assurance program.
J. Other information that the Pennsylvania Department of Health or the Insurance Department may require.

Confidentiality and Disclosure of Medical Information

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

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

Policy Year

For purposes of the provisions of the Patient Protection and Affordable Care Act with respect to the Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions the Policy Year for this Agreement will be a Calendar Year.

WELCOME

Thank you for joining Keystone. Our goal is to provide you with access to quality health care coverage. This Subscriber Agreement ("Agreement") describes your benefits and the procedures required in order to receive the benefits and services to which you are entitled. Your specific benefits covered by the HMO are described in Section CS – Description Of Covered Services of this Agreement. If changes are made to this Agreement, you will be notified by the HMO. Changes to the Agreement will apply to benefits for services received after the effective date of change.

Please read your Agreement thoroughly and keep it handy. It will answer most of your questions regarding the HMO's procedures and services. **If you have any other questions, call or write the HMO Customer Service Department ("Customer Service") at the telephone number and address shown on the back of your HMO Identification Card ("ID Card"). Or you may write to Customer Service at:**

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

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

YOUR ID CARD

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

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

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

SECTION DE - DEFINITIONS

For the purposes of this Agreement, the terms below have the following meaning:

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

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

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

ALCOHOL OR DRUG ABUSE AND DEPENDENCY TREATMENT FACILITY – a facility which is licensed by the Department of Health as an alcoholism or drug addiction treatment program that is primarily engaged in providing Detoxification and rehabilitation treatment for Alcohol Or Drug Abuse And Dependency.

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

A. For services provided by a Participating Facility Provider, the term "Allowed Amount" is the HMO's fee schedule amount.
B. For services provided by a Participating Professional Provider, "Allowed Amount" is the HMO's fee schedule amount.
C. For services provided by Participating Ancillary Service Providers, "Allowed Amount" means the amount that the HMO has negotiated with the Participating Ancillary Service Provider as total reimbursement for the Covered Services.
D. For Pediatric Dental Covered Services provided by a Participating Dentist, Allowed Amount means the Maximum Allowable Charge (MAC) for the specific Pediatric Dental Covered Service. Participating Dentists accept contracted MACs as payment in full for Pediatric Dental Covered Services.

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE – complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM). NCCAM is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications:

A. Alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine);
B. Mind-body interventions (a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms, e.g., meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance);
C. Biologically based therapies using natural substances, such as herbs, foods, vitamins, or

nutritional supplements to prevent and treat illness. (e.g., diets, macrobiotics, megavitamin therapy);

D. Manipulative and body-based methods (e.g., massage, equestrian/hippotherapy); and

E. Energy therapies, involving the use of energy fields. They are of two types:

1. Biofield therapies - intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi Gong, Reiki, and therapeutic touch.
2. Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the HMO and which:

A. Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;

B. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

C. Does not provide Inpatient accommodations; and

D. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

ANCILLARY SERVICE PROVIDER - an individual or entity that provides services, supplies or equipment (such as, but not limited to, Infusion Therapy Services, Durable Medical Equipment and ambulance services), for which benefits are provided under the coverage.

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

APPLICANT - the person who applies for coverage under this Agreement and with whom the HMO has contracted to provide this coverage.

APPLICATION/CHANGE FORM – the properly completed written request for enrollment for HMO membership submitted in a format provided by the HMO, together with any amendments or modifications thereof, identified as the Application/Change Form and Health Questionnaire.

ATTENTION DEFICIT DISORDER - a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

AVERAGE WHOLESALE PRICE (AWP) – composite wholesale price for a drug designated by the manufacturer. This does not necessarily represent what Pharmacists pay for a drug, but it does serve as an accepted pricing benchmark. AWP's are compiled in two (2) reference sources: The Red Book and First DataBank (the National Drug Data File).

AWAY FROM HOME CARE COORDINATOR – the staff whose functions include assisting Members with registering as a Guest Member for Guest Membership Benefits under the Away From Home Care Program.

AWAY FROM HOME CARE PROGRAM – a program, made available to independent licensees of the Blue Cross Blue Shield Association, that provides Guest Membership Benefits to Members registered for the Program while traveling out of Keystone's Service Area for an extended period of time. The Away From Home Care Program offers portable HMO coverage to Members traveling in a Host HMO Service Area. Registration for Guest Membership Benefits under the Away From Home Care Program is coordinated by the Away From Home Care Coordinator.

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

BIRTH CENTER - a Facility Provider approved by the HMO which: (1) is licensed as required in the state where it is situated; (2) is primarily organized and staffed to provide maternity care; and (3) is under the supervision of a Physician or a licensed Certified Nurse Midwife.

BLUECARD PROGRAM – a program that enables Members obtaining health care services while traveling outside Keystone's Service Area to receive all the same benefits of their HMO plan and access to BlueCard Providers and savings. The program links participating health care providers and the independent Blue Cross and Blue Shield Licensees across the country and also to some international locations through a single electronic network for claims processing and reimbursement.

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

CASE MANAGEMENT – comprehensive case management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Member to ensure the efficient use of appropriate health care resources, link Members with appropriate health care or support services, assist PCP's and Referred Specialists in coordinating Prescribed services, monitor the quality of services delivered, and improve Member outcomes. Case Management supports Members, PCP's and Referred Specialists by locating, coordinating, and/or evaluating services for a Member who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

CERTIFIED REGISTERED NURSE - a Certified Registered Nurse anesthetist, Certified Registered Nurse practitioner, certified 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 REHABILITATIVE THERAPY – medically Prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system insult (e.g. trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or re-establish

previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities which mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a Physician, neuropsychologist, Psychologist, as well as a physical, occupational or speech therapist using a team approach.

COINSURANCE - the percentage of the HMO fee schedule amount which must be paid by the Member (such as 20 percent). The Coinsurance percentage is listed in Section SC - Schedule Of Cost Sharing & Limitations.

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

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

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

COMPLAINT – a dispute or objection regarding coverage, including exclusions and non-Covered Services under the plan, Participating or Non-Participating Providers' status or the operations or management policies of the HMO. This definition does not include a Grievance (Medical Necessity appeal). It also does not include disputes or objections that were resolved by the HMO and did not result in the filing of a Complaint (written or oral).

CONDITIONS FOR DEPARTMENTS (for Qualifying Clinical Trials) – the conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:

A. To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
B. Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

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

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

COORDINATION OF BENEFITS (COB) – a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims, and by providing the authority

for the orderly transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, that plan does not have to pay benefits first. This provision does not apply to student accident or group hospital indemnity plans paying one hundred dollars ($100) per day or less.

COPAYMENT – a specified dollar amount applied to a specific Covered Service for which the Member is responsible per Covered Service. Copayments, if any, are identified in Section SC - Schedule Of Cost Sharing & Limitations.

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

A. Prescription Drugs Prescribed by a Primary Care Physician or Referred Specialist subject to the Prescription Drug Exclusions, and other exclusions listed in the Subscriber Agreement;
B. Compounded Prescription Drugs containing at least one Legend Drug or Controlled Substance in an amount requiring a Prescription Drug Order or Refill;
C. Insulin (by Prescription Order only); or
D. Spacers for metered dose inhalers (by Prescription Order only).

COVERED SERVICE – a service or supply specified in the Agreement and summarized in Section CS – Description Of Covered Services for which benefits will be provided.

CUSTODIAL CARE (DOMICILIARY CARE) – care provided primarily for Maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision of self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DAY REHABILITATION PROGRAM – is a level of Outpatient Care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Subscriber Agreement and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Member returns home each evening and for the entire weekend.

DECISION SUPPORT – describes a variety of services that help Members make educated decisions about health care and support their ability to follow their PCP's and Participating Specialist's treatment plans. Some examples of Decision Support services include support for major treatment decisions and information about everyday health concerns.

DENTALLY NECESSARY (DENTAL NECESSITY) - a dental service or procedure is determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the HMO. When there is a conflict of opinion between the Dentist and the HMO on whether or not a dental service or procedure is Dentally Necessary, the opinion of the HMO will be final.

DENTIST – a person licensed to practice dentistry in the state in which dental services are provided. Dentist will include other duly licensed dental practitioners under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

DEPENDENT – an Enrollee's legal spouse who resides in the Service Area or an Enrollee's child who meets all the eligibility requirements as established by the HMO plan and as described in the Eligibility section of this Handbook.

DESIGNATED PROVIDER – a Participating Provider with whom the HMO has contracted the following outpatient services: (a) certain Rehabilitation Therapy Services (other than Speech Therapy); (b) diagnostic radiology services for Members age five (5) or older; and (c) laboratory and pathology tests. The Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

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

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

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

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

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

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

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

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

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

F. Demonstrates financial interdependence by submission of proof of three (3) or more of the following documents:
    1. A Domestic Partnership agreement;
    2. A joint mortgage or lease;
    3. A designation of one of the partners as beneficiary in the other partner's will;
    4. A durable property and health care powers of attorney;
    5. A joint title to an automobile, or joint bank account or credit account; or
    6. Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

The HMO reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

DRUG FORMULARY (FORMULARY) - A listing of Prescription Drugs, preferred for use by the HMO. This list shall be subject to periodic review and modification by the HMO. Covered Drugs not listed in the Drug Formulary shall be subject to the Non-Preferred Drug cost share.

DURABLE MEDICAL EQUIPMENT (DME) - equipment that meets all of these tests:
A. It is Durable. (This is an item that can withstand repeated use.)
B. It is Medical Equipment. (This is equipment that is primarily and customarily used for medical purposes, and is not generally useful in the absence of illness or injury.)
C. It is generally not useful to a person without an illness or injury.
D. It is appropriate for use in the home.

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

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

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

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

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

ESSENTIAL HEALTH BENEFITS - a set of health care service categories that must be covered by certain plans in accordance with the Affordable Care Act. The Affordable Care Act ensures health plans offered in the individual and small group markets offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXPERIMENTAL/INVESTIGATIVE – a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing Clinical Trials;
B. Is the research, experimental, study or investigational arm of an on-going Clinical Trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
C. Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process (e.g., an Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets 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 investigative settings.
E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

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

A. Ambulatory Surgical Facility
B. Birth Center
C. Freestanding Dialysis Facility
D. Freestanding Ambulatory Care Facility
E. Home Health Care Agency
F. Hospice
G. Hospital
H. Non-Hospital Facility
I. Psychiatric Hospital
J. Rehabilitation Hospital
K. Residential Treatment Facility
L. Short Procedure Unit
M. Skilled Nursing Facility

FOLLOW-UP CARE – care scheduled for Medically Necessary follow-up visits that occur while the Member is away from home. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is still at home. An example is Dialysis. Follow-Up Care must be Preapproved by the Member's Primary Care Physician prior to traveling. This service is available through the BlueCard Program for temporary absences (less than ninety (90) consecutive days) from Keystone's Service Area.

FREESTANDING 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.

FREESTANDING DIALYSIS FACILITY - a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the HMO, which is primarily engaged in providing Dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.

GENERIC DRUG – pharmacological agents approved by the FDA as a bioequivalent substitute and manufactured by a number of different companies as a result of the expiration of the original patent.

GRIEVANCE – a request by a Member or a health care Provider, with the written consent of the Member, to have the HMO reconsider a decision solely concerning the Medical Necessity or appropriateness of a health care service. This definition does not include a Complaint. It also does not include disputes or objections regarding Medical Necessity that were resolved by the HMO and did not result in the filing of a Grievance (written or oral).

GUEST MEMBER – a Member who has a pre-authorized Guest Member registration in a Host HMO Service Area for a defined period of time. After that period of time has expired, the Member must again meet the eligibility requirements for Guest Membership Benefits under the Away From Home Care Program and re-enroll as a Guest Member to be covered for those benefits.

A Subscriber's eligible Dependent may register as a 'Student Guest Member'. The Dependent must be a student residing outside Keystone's Service Area and inside a Host HMO Service Area. The Dependent student must not be residing with the Subscriber and must be residing in a Host HMO Service Area.

GUEST MEMBERSHIP (GUEST MEMBERSHIP PROGRAM) – a program that provides Guest Membership Benefits to Members while traveling out of Keystone's Service Area for a period of at least ninety (90) consecutive days. Guest Membership Benefits provide coverage for a wide range of health care services. The Guest Membership Program offers portable Keystone coverage to Members of plans contracting in Keystone's network. Services provided under the Guest Membership Program are coordinated by the Guest Membership Coordinator. Guest Membership is available for a limited period of time. The Guest Membership Coordinator will confirm the period for which you are registered as a Guest Member.

GUEST MEMBERSHIP BENEFITS – benefits available to Members while traveling out of Keystone's Service Area for a period of at least ninety (90) consecutive days. Guest Membership Benefits provide coverage for a wide range of health care services. Members can register for Guest Membership Benefits available under the Away From Home Care Program by contacting the Away From Home Care Coordinator. The Away From Home Care Coordinator will also confirm the period for which the Member is registered as a Guest Member since Guest Membership Benefits are available for a limited period of time.

GUEST MEMBERSHIP COORDINATOR – the staff that assists Members with registration for Guest Membership and provides other assistance to Members while Guest Members.

HABILITATION THERAPY (HABILITATIVE SERVICES) – health care services that help a Member keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEARING AID – a Prosthetic Device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of (a) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound to the ear, and (d) a battery for power. A Hearing Aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a Hearing Aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely-in-the-canal, or (e) implanted (can be partial or complete). A Hearing Aid is not a cochlear implant.

HOME – for purposes of the Home Health Care and Homebound Covered Services only, this is the place where the Member lives. This may be a private residence/domicile, an assisted living facility, a long-term care facility or a Skilled Nursing Facility at a custodial level of care.

HOME HEALTH CARE PROVIDER – a licensed Provider that has entered into an agreement with the HMO to provide home health care Covered Services to Members on an intermittent basis in the Member's Home in accordance with an approved home health care Plan of Treatment.

HOMEBOUND – when there exists a normal inability to leave Home due to severe restrictions on the Member's mobility and when leaving the Home:(a) would involve a considerable and taxing effort by the Member; and (b) the Member is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

HOSPICE - a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

HOSPITAL - a short term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the HMO and which:

A. Is a duly licensed institution;
B. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
C. Has organized departments of medicine;
D. Provides 24 hour nursing service by or under the supervision of Registered Nurses;
E. Is not, other than incidentally, a: Skilled Nursing Facility; nursing home; Custodial Care home; health resort, spa or sanitarium; place for rest; place for aged; place for treatment of Mental Illness; place for treatment of Alcohol Or Drug Abuse And Dependency; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

HOSPITAL SERVICES - except as limited or excluded herein, acute-care Covered Services furnished by a Hospital which are Referred by your Primary Care Physician or provided by your Participating Specialist and Preapproved by the HMO where required. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

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

HOST HMO – the contracting HMO through which a Member can receive Away From Home Care Covered Services as a Guest Member when traveling in the Host HMO Service Area.

HOST HMO SERVICE AREA – a Host HMO's approved geographical area within which the Host HMO is approved to provide access to Covered Services.

IDENTIFICATION CARD (ID CARD) – the currently effective card issued to the Member by the HMO which must be presented when a Covered Service is requested.

IMMUNIZATIONS – pediatric and adult immunizations (except those required for employment or travel), including the agents used for the immunizations. All immunizations, including the agents used for them, must 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 schedules may be found in the Preventive Schedule document.

INCURRED – a charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

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

INDEPENDENT REVIEW ORGANIZATION (IRO) – an entity qualified by applicable licensure and/or accreditation standards to act as the independent decision maker on external Medical Necessity Appeals requiring evaluation of issues related to Medical Necessity of a Member's request for Covered Services. The HMO arranges for the availability of IRO's and assigns them to external Medical Necessity Appeals and issues pertaining to recessions of coverage (except for non-payment of premiums or contributions). IROs are not corporate affiliates of the HMO.

INPATIENT CARE - treatment received as a bed patient in a Hospital, a Rehabilitation Hospital, a Skilled Nursing Facility or a Participating Facility Provider that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

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

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

KEYSTONE HEALTH PLAN EAST, INC. ("KEYSTONE" or **"the HMO")** - a health maintenance organization providing access to comprehensive health care to Members.

LEGEND DRUG – any medicinal substance which is required by the Federal Food, Drug and Cosmetic Act to be labeled as "Caution: Federal law prohibits dispensing without a prescription."

LICENSED CLINICAL SOCIAL WORKER – A social worker who has graduated from 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 had graduated from a practical or nursing education program and is licensed by the appropriate state authority.

LIFE-THREATENING DISEASE OR CONDITION (for Qualifying Clinical Trials) – any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LIMITATIONS – the maximum number of Covered Services, measured in number of visits or days, or the maximum dollar amount of Covered Services that are eligible for coverage. Limitations may vary depending on the type of program and Covered Services provided. Limitations, if any, are identified in Section SC – Schedule Of Cost Sharing & Limitations.

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

The Limiting Age for Dependents is 26.

MAINTENANCE – continuation of care and management of the Member when:

A. The maximum therapeutic value of a Medically Necessary treatment plan has been achieved;
B. No additional functional improvement is apparent or expected to occur;
C. The provision of Covered Services ceases to be of therapeutic value; and
D. It is no longer Medically Necessary.

This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

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

MASTERS PREPARED THERAPIST – a therapist who holds a Master's Degree in an acceptable human services-related field of study and is licensed as a therapist at an independent practice level by the appropriate state authority to provide therapeutic services for the treatment of mental health care and Serious Mental Illness.

MAXIMUM ALLOWABLE CHARGE(S) - the greatest amount the Contract will allow for a specific Pediatric Dental service.

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

MEDICAL DIRECTOR – a Physician designated by the HMO to design and implement quality assurance programs and continuing education requirements, and to monitor utilization of health services by Members.

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

MEDICAL POLICY (MEDICAL POLICIES) – a 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.

MEDICAL SCREENING EVALUATION – an examination and evaluation within the capability of the Hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel.

MEDICAL TECHNOLOGY ASSESSMENT – technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include and are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The HMO uses the technology assessment process to assure that new drugs, procedures or devices are safe and effective before approving them as a Covered Service. When new technology becomes available or at the request of a practitioner or Member, the HMO researches all scientific information available from these expert sources. Following this analysis, the HMO makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service.

MEDICALLY NECESSARY (MEDICAL NECESSITY) – shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

MEDICARE – The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

MEMBER – a Subscriber or Dependent who meets the eligibility requirements for enrollment and is contractually entitled to receive Covered Services pursuant to this Subscriber Agreement.

MENTAL ILLNESS – any of various conditions categorized as mental disorders by the most recent edition of the International Classification of Diseases (ICD), wherein mental treatment is provided by a qualified Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

NON-HOSPITAL FACILITY – A facility Provider, licensed by the Department of Health for the care or treatment of Members diagnosed with Alcohol or Drug Abuse And Dependency, except for transitional living facilities.

Non-Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities Free Standing Ambulatory Care Facilities for Partial Hospitalization Programs.

NON-PARTICIPATING DENTIST - a Dentist who has not contracted to limit their charges to Members.

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

NON-PARTICIPATING PROVIDER - a Facility Provider, Professional Provider, Ancillary Service Provider that is not a member of the HMO's Network.

NON-PREFERRED DRUGS – These drugs generally have one or more generic alternatives or preferred brand options within the same drug class.

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

OCCUPATIONAL THERAPY – medically Prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically Prescribed treatment concerned with improving the Member's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

OFFICE VISITS – Covered Services provided in the Physician's office and performed by or under the direction of your Primary Care Physician or a Participating Specialist.

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.

OUT-OF-AREA – outside of Keystone's Service Area. Covered Services are limited to: (a) Emergency Services and services that are arranged or Referred by your Primary Care Physician in Keystone's Service Area and Preapproved by the HMO; (b) Urgent Care and Follow-Up Care available through the BlueCard Program; and (c) services provided to a Member registered as a Guest Member under the Away From Home Care Program.

OUT-OF-POCKET MAXIMUM – the maximum dollar amount that a Member pays for Covered Services under this Subscriber Agreement in each Benefit Period as shown in Section SC-Schedule Of Cost Sharing & Limitations. The Out-of-Pocket Maximum includes Copayments and Coinsurance amounts; it does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Subscriber Agreement.

OUTPATIENT CARE (OUTPATIENT) – medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a Hospital or other inpatient facility.

OUTPATIENT MENTAL HEALTH CARE/OUTPATIENT SERIOUS MENTAL ILLNESS HEALTH CARE/OUTPATIENT ALCOHOL OR DRUG ABUSE AND DEPENDENCY TREATMENT (OUTPATIENT TREATMENT) – the provision of medical, nursing, counseling or therapeutic Covered Services on a planned and regularly scheduled basis at a Participating Facility Provider licensed by the Department of Health as an Alcohol Or Drug Abuse And Dependency treatment program or any other mental health or Serious Mental Illness therapeutic modality designed for a patient or Member who does not require care as an Inpatient. Outpatient Treatment includes care provided under a Partial Hospitalization program or an Intensive Outpatient Program.

PARTIAL HOSPITALIZATION – Medical, nursing, counseling or therapeutic services that are 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 DENTIST(S) - a Dentist who has executed an agreement, under which they agree to accept Maximum Allowable Charges as payment in full for Pediatric Dental Covered

Services. Participating Dentists may also agree to limit their charges for any other services delivered to Members.

PARTICIPATING FACILITY PROVIDER – a Facility Provider that is a member of the HMO's network.

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

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

PARTICIPATING PROFESSIONAL PROVIDER – a Professional Provider who is a member of the HMO's network.

PARTICIPATING PROVIDER - a Facility Provider, Professional Provider or Ancillary Services Provider with whom the HMO has contracted directly or indirectly and, where applicable, is Medicare certified to render Covered Services. This includes, but is not limited to:

A. **Primary Care Physician (PCP)** - a Professional Provider selected by a Member who is responsible for providing all primary care Covered Services and for authorizing and coordinating all covered Medical Care, including Referrals for Specialist Services.

B. **Participating Specialist** – a Professional Provider who provides Specialist Services with a Referral or, for direct access care, without a Referral. A Participating Specialist is in one of the following categories:

1. **Referred Specialist** – a Professional Provider who provides Covered Specialist Services within his or her specialty upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide these services, Referral to a Non-Participating Provider will be arranged by your Primary Care Physician with Preapproval by the HMO. See Section ACC - Access to Primary, Specialist and Hospital Care for procedures for obtaining Preapproval for use of a Non-Participating Provider.

   For the following outpatient services, the Referred Specialist is your Primary Care Physician's Designated Provider: (a) certain Rehabilitation Therapy Services (other than Speech Therapy); (b) certain diagnostic radiology services for Members age five (5) or older; and (c) laboratory and pathology tests. Your Primary Care Physician will provide a Referral to the Designated Provider for these services.

2. **Participating Obstetricians or Gynecologists** – a Participating Provider selected by a female Member who provides Covered Services without a Referral. All non-facility obstetrical and gynecological Covered Services are subject to the same Copayment that applies to Office Visits to your PCP. Participating obstetricians and gynecologists have the same responsibilities as Referred Specialists. For example, seeking Preapproval for certain services. Similarly, just as you have the right to designate a Referred Specialist as your PCP, you may designate a Participating Obstetrician or Gynecologist as your PCP.

3. **Dialysis Specialist** - a Professional Provider who provides services related to Dialysis without a Referral.

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

D. **Durable Medical Equipment (DME) Provider** - a Participating Provider of Durable Medical Equipment that has contracted with the HMO to provide Covered Supplies to Members.

E. **Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider** – a Provider in a network made up of professionals and facilities contracted by a behavioral health management company on the HMO's behalf to provide behavioral health/Alcohol Or Drug Abuse And Dependency Covered Services for the treatment of Mental Illness, Serious Mental Illness and Alcohol Or Drug Abuse And Dependency, (including Detoxification) to the HMO's Members. Licensed Clinical Social Workers and Masters Prepared Therapists are contracted to provide Covered Services for treatment of mental health care and Serious Mental Illness only.

F. **Hospice Provider** - a licensed Participating Provider that is primarily engaged in providing pain relief, symptom management, and supportive services to a terminally ill Member with a medical prognosis of six (6) months or less. Covered Services to be provided by the Hospice Provider include Home Hospice and/or Inpatient Hospice services that have been Referred by your Primary Care Physician and Preapproved by the HMO.

PEDIATRIC DENTAL COVERED SERVICE(S) - dental services shown on Section SC – Schedule of Cost Sharing & Limitations for which benefits will be covered subject to this Agreement when rendered by a Participating Dentist.

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

PHARMACIST – an individual, duly licensed as a Pharmacist by the State Board of Pharmacy or other governing body having jurisdiction, who is employed by or associated with a pharmacy.

PHARMACY AND THERAPEUTICS COMMITTEE – a group composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee consists of at least two-thirds licensed and actively practicing

Physicians and Pharmacists; and shall consist of at least one Pharmacist.

PHYSICAL THERAPY – medically Prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

PHYSICIAN - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

PLAN OF TREATMENT – a plan of care which is developed or approved by your Primary Care Physician for the treatment of an injury or illness. The Plan of Treatment should be limited in scope and extent to that care which is Medically Necessary for the Member's diagnosis and condition.

PREAPPROVED (PREAPPROVAL) – the approval which your Primary Care Physician or Participating Specialist must obtain from the HMO to confirm the HMO coverage for certain Covered Services, or Medical Necessity for certain Covered Drugs or Supplies for a Member's medical condition.

With regard to your medical services, such approval must be obtained prior to providing Members with Covered Services or Referrals. If your Primary Care Physician or Participating Specialist is required to obtain a Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, you will not be responsible for payment. Preapproval is not required for a maternity Inpatient Stay.

With regard to Prescription Drug benefits, such Preapproval must be obtained prior to providing the Covered Drug or Supply. The HMO also reserves the right to apply dispensing limits for certain Covered Drugs or Supplies as conveyed by the FDA or the HMO's Pharmacy and Therapeutics Committee. The Member may call Customer Service at the telephone number shown on the back of his or her ID Card to find out if the Covered Drug or Supply has been approved by the HMO, or may ask the Primary Care Physician to call Provider Services.

Approval will be given by the appropriate HMO staff under the supervision of the Medical Director.

PREFERRED BRAND – These drugs have been selected for their reported medical effectiveness, safety, and value. These drugs generally do not have generic equivalents.

PRENOTIFICATION – the requirement that a Member provide prior notice to the HMO that proposed services, such as maternity care, are scheduled to be performed. Payment for services depends on whether the Member and the category of service are covered under this HMO plan.

PRESCRIBE (PRESCRIBED) – to write or give a Prescription Order.

PRESCRIPTION COST SHARING MAXIMUM - the maximum dollar amount a Member will pay toward Covered Drugs or Supplies per Prescription Drug Order or Refill. The maximum dollar amount that applies is shown in Section SC - Schedule Of Cost Sharing & Limitations.

PRESCRIPTION DRUG – a Legend Drug or Controlled Substance, which has been approved by the Food and Drug Administration for a specific use and which can, under federal or state law, be dispensed only by a licensed Pharmacist pursuant to a Prescription Order. You may call Customer Service at the telephone number shown on your ID Card to find out if your Prescription Drug has been approved by the HMO or you may ask your Primary Care Physician to call Provider Services.

This definition includes insulin and spacers for metered dose inhalers obtained with a Prescription Drug Order or Refill.

PRESCRIPTION DRUG ALLOWED AMOUNT – the dollar amount for a Covered Drug or Supply upon which the Member's cost will be determined. The Prescription Drug Allowed Amount varies, based on where the Prescription Drug Order or Refill is dispensed:

A. If the Covered Drug or Supply is dispensed by a Participating Pharmacy or Participating Mail Order Pharmacy, the amount is determined by the pharmacy agreement.

B. If the Covered Drug or Supply is dispensed by a Non-Participating Pharmacy, it is the lesser of (a) the Non-Participating Pharmacy's charges for the Covered Drug or Supply or (b) 150% of the Average Wholesale Price for the Covered Prescription Drug. The Prescription Drug Allowed Amount may differ from the Non-Participating Pharmacy's charge. Any difference will be the responsibility of the Member.

PRESCRIPTION DRUG COINSURANCE – that portion of the Prescription Drug Allowed Amount charged to the Member for a Prescription Drug Order Or Refill of a Covered Drug Or Supply. The Prescription Drug Coinsurance is a percentage of the Prescription Drug Allowed Amount. The percentage that applies is shown in Section SC –Schedule Of Cost Sharing & Limitations. The Prescription Drug Coinsurance varies based on where the Prescription Drug Order Or Refill is dispensed:

A. Participating Pharmacy or Participating Mail Service Pharmacy - The Member is responsible, at the time of service, for payment of the Prescription Drug Coinsurance amount.

B. Non-Participating Pharmacy - The Member is responsible, at the time of service, to pay the entire cost of the Covered Drug Or Supply. The Member must submit to the HMO acceptable proof of payment with a direct reimbursement form. All claims for payment must be received by the HMO or an agent of the HMO within ninety (90) days of the date of purchase. Direct reimbursement forms may be obtained by contacting Customer Service. If the Prescription Drug is a Covered Drug Or Supply, the Member will be reimbursed an amount equal to the difference between the Prescription Drug Allowed Amount and the Non-Participating Pharmacy Prescription Drug Coinsurance Amount.

PRESCRIPTION DRUG COPAYMENT (PRESCRIPTION DRUG COPAY) – the amount as shown in Section SC –Schedule Of Cost Sharing & Limitations charged to the Member by the Participating Retail Pharmacy or Participating Mail Service Pharmacy for the dispensing or refilling of any Prescription Drug Order or Refill. The Member is responsible at the time of service for payment of the Prescription Drug Copay directly to the Participating Retail Pharmacy or Participating Mail Service Pharmacy.

PRESCRIPTION DRUG ORDER OR REFILL (PRESCRIPTION DRUG ORDER) - the authorization for a Prescription Drug, issued by a Primary Care Physician or Participating Specialist who is duly licensed to make such an authorization in the ordinary course of that Provider's professional practice.

PRESCRIPTION ORDER - the authorization for: 1) a Prescription Drug, or 2) services or supplies Prescribed for the diagnosis or treatment of an illness, which are issued by a Primary Care Physician or Participating Specialist who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

PRIVATE DUTY NURSING - Medically Necessary continuous skilled nursing services provided to a Member by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

PROFESSIONAL PROVIDER - a person or practitioner who is certified, registered or who is licensed and performing services within the scope of such licensure. The Professional Providers are:

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

PROSTHETIC DEVICE - devices (except dental Prosthetic Devices), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

PROVIDER - any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Rehabilitation Hospital, birthing facility, or Home Health Care Provider. In addition, for Mental Health Care and Serious Mental Illness services only, a Licensed Clinical Social Worker and a Masters Prepared Therapist will also be considered a Provider.

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

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

QUALIFIED INDIVIDUAL (for Clinical Trials) – a Member who meets the following conditions:

A. The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and

B. Either:

1. The referring health care professional is a health care Provider participating in the clinical trial and has concluded that the Member's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or

2. The Member provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Member meeting the conditions described above.

QUALIFYING CLINICAL TRIAL – a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:

A. Federally funded trials: the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1. The National Institutes of Health (NIH);
2. The Centers for Disease Control and Prevention (CDC);
3. The Agency for Healthcare Research and Quality (AHRQ);
4. The Centers for Medicare and Medicaid Services (CMS);
5. Cooperative group or center of any of the entities described in 1-4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
6. Any of the following, if the Conditions For Departments are met:

a. The Department of Veterans Affairs (VA);
b. The Department of Defense (DOD); or
c. The Department of Energy (DOE).

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the clinical trial must be approved by the HMO as a Qualifying Clinical Trial.

REFERRED (REFERRAL) – electronic documentation from the Member's Primary Care Physician that authorizes Covered Services to be rendered by a Participating Provider or group of Providers or the Provider specifically named on the Referral. Referred care includes all services provided by a Referred Specialist. Referrals to Non-Participating Providers must be Preapproved by the HMO. A Referral must be issued to the Member prior to receiving Covered Services and is valid for ninety (90) days from the date of issue for an enrolled Member. See Section ACC - Access to Primary, Specialist and Hospital Care for procedures for obtaining Preapproval for use of a Non-Participating Provider.

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

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

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

REHABILITATION THERAPY (REHABILITATIVE SERVICES) - includes treatments designed to improve, maintain, and prevent the deterioration of skills and functioning for daily living that have been lost or impaired. Rehabilitation Therapy includes Physical Therapy, Occupational Therapy and Speech Therapy.

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.

RESIDENTIAL TREATMENT FACILITY - a Facility Provider, licensed and approved by the appropriate government agency and approved by the HMO, which provides treatment for Mental Illness, Serious Mental Illness or for Alcohol Or Drug Abuse And Dependency to partial, outpatient or live-in patients who do not require acute Medical Care.

RESPITE CARE – Hospice services necessary to relieve primary caregivers, provided on a short term basis, in a Medicare certified Skilled Nursing Facility, to a Member for whom Hospice care is provided primarily in the home.

RETAIL CLINIC - retail clinics are staffed by certified nurse practitioners trained to diagnose, treat and write prescriptions when clinically appropriate. Services are available to treat basic medical needs for Urgent Care. Examples of needs are sore throat; ear, eye or sinus infection; allergies; minor burns; skin infections or rashes; and pregnancy testing.

RIDER – a legal document which modifies the protection of the Agreement, either by expanding, decreasing or defining benefits, or adding or excluding certain conditions from coverage under this Agreement.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS - routine patient costs include all items and services consistent with the coverage provided under this Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

A. The investigational item, device, or service itself;
B. Items and services that are provided solely to satisfy data collection and analysis needs

and that are not used in the direct clinical management of the patient; and

C. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SELF-ADMINISTERED PRESCRIPTION DRUG - a Prescription Drug that can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self-Administered Prescription Drugs include, but are not limited to:

- Oral drugs;
- Self-Injectable Drugs;
- Inhaled drugs; and
- Topical drugs.

SELF-INJECTABLE PRESCRIPTION DRUG (SELF-INJECTABLE DRUG) – a Prescription Drug that:
(a) is introduced into a muscle or under the skin with a syringe and needle; and
(b) can be administered safely and effectively by either the Member or a caregiver without medical supervision regardless of whether initial medical supervision and/or instruction is required.

SERIOUS MENTAL ILLNESS - means any of the following biologically based mental illnesses as defined by the American Psychiatric Association in the most recent edition of the diagnostic and statistic manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder, and any other mental illness that is considered to be "Serious Mental Illness" by law.

SERVICE AREA – the geographical area within which the HMO is approved to provide access to Covered Services.

SEVERE SYSTEMIC PROTEIN ALLERGY – means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT - a unit which is approved by the HMO and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient Stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol Or Drug Abuse And Dependency and has contracted with the HMO to provide Covered Services to Members, which:

A. Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
B. Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
C. Is otherwise acceptable to the HMO.

SLEEP STUDIES - refers to the continuous and simultaneous monitoring and recording of various physiologic and pathophysiologic sleep parameters. Sleep tests are performed to diagnose sleep disorders (e.g., narcolepsy, sleep apnea, parasomnias), initiate treatment for a sleep disorder and/or evaluate an individual's response to therapies such as continuous positive airway pressure (CPAP) or bi-level positive airway pressure device (BPAP).

SOUND NATURAL TEETH – teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury or trauma, and are not man-made.

SPECIALIST SERVICES – all Physician services providing Medical Care or mental health care in any generally accepted medical or surgical specialty or subspecialty.

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

A. The drug is used in the treatment of a rare, complex, or chronic disease.
B. A high level of involvement is required by a healthcare Provider to administer the drug.
C. Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
D. The drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance.
E. Access to the drug may be limited.

The HMO reserves the right to determine which Specialty Drug vendors and/or healthcare Providers can dispense or administer certain Specialty Drugs.

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

STANDING REFERRAL (STANDING REFERRED) – documentation from the HMO that authorizes Covered Services for a life-threatening, degenerative or disabling disease or condition. The Covered Services will be rendered by the Referred Specialist named on the Standing Referral form. The Referred Specialist will have clinical expertise in treating the disease or condition.

A Standing Referral must be issued to the Member prior to receiving Covered Services. The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid. Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

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

SUBSCRIBER – a person who meets all applicable eligibility requirements as described under Section EL - Eligibility, Change And Termination Rules Under The Plan, is enrolled for coverage under this Agreement, is subject to premium requirements as described in the Premium Rates subsections of Section GP – General Provisions, and has been accepted for coverage by the HMO.

SUBSCRIBER AGREEMENT (AGREEMENT) – this agreement between the HMO and the Subscriber, including the Application/Change Form, schedules, Riders and/or amendments if any.

SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered Surgery.

THERAPY SERVICES - the following services or supplies Prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Member:

A. Cardiac Rehabilitation Therapy
Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

B. Chemotherapy
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells.

C. Dialysis
Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. Infusion Therapy
The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a healthcare Provider. Infusion Therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the HMO.

E. Pulmonary Rehabilitation Therapy
Multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

F. Radiation Therapy
The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes, or other radioactive substances regardless of the method of delivery.

G. Respiratory Therapy
Medically Prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

URGENT CARE –urgent care needs are for sudden illness or Accidental Injury that require prompt medical attention, but are not life-threatening and are not Emergency medical conditions, when your Primary Care Physician is unavailable. Examples of urgent care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not

Preventive Care or Follow-up Care.

URGENT CARE CENTER – a Participating Facility Provider designed to offer immediate evaluation and treatment for acute health conditions that require medical attention in a non-Emergency situation that cannot wait to be addressed by your Primary Care Physician's office or Retail Clinic. Urgent Care is not the same as Emergency Services (see definition of Urgent Care above).

WAITING PERIOD(S) - a period of time an eligible Member must be enrolled under the Contract before benefits will be paid for Medically Necessary Orthodontics services under the Pediatric Dental Covered Services benefit as shown in Section SC – Schedule of Cost Sharing & Limitations and Section CS - Description of Covered Services.

SECTION MC – USING THE HMO SYSTEM

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

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

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

- **When you need Specialist Services** your Primary Care Physician will give you an electronic Referral for specific care or will obtain a Preapproval from the HMO when required. A Standing Referral may be available to you if you have a life-threatening, degenerative or disabling disease or condition.

  Female Members may visit any participating obstetrical/gynecological Specialist without a Referral. This is true whether the visit is for preventive care, routine obstetrical/gynecological care or problem-related obstetrical/gynecological conditions. Your Primary Care Physician must obtain a Preapproval for Specialist Services provided by Non-Participating Providers.

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

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

- **Some services must be Preapproved by the HMO.** Your Primary Care Physician or Participating Specialist works with the HMO's Care Management and Coordination team during the Preapproval process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you. You have the right to appeal any decisions through the Complaint and Grievance Appeal Process. Instructions for the appeal will be described in the denial notifications.

- **All services must be received from Keystone Participating Providers unless Preapproved by the HMO, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area.** See Section ACC - Access to Primary, Specialist and Hospital Care for direction on obtaining Preapproval for use of a Non-Participating Provider. Use your Provider Directory to find out more about the individual Providers, including Hospitals and Primary Care Physicians and Participating Specialists and their affiliated Hospitals. It includes a foreign language index to help you locate a

Provider who is fluent in a particular language. The directory also lists whether the Provider is accepting new patients.

- **To change your Primary Care Physician,** call Customer Service at the telephone number shown on the ID Card.

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

  A. Physical and occupational therapy;
  B. Diagnostic Services for Members age five (5) and older;
  C. Laboratory and Pathology Tests.

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

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

  Before selecting your Primary Care Physician, you may want to speak to the Primary Care Physician regarding his/her Designated Providers.

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

- **Prescription Drugs are covered under your HMO program.** Under this HMO plan, Prescription Drugs, including medications and biologicals, are Covered Services or Supplies when ordered during your Inpatient Hospital stay. In addition, you also have Prescription Drug coverage for outpatient Prescription Drugs.

  Prescription Drug benefits do not cover over-the-counter drugs except insulin or over-the counter drugs that are Prescribed by a Physician in accordance with applicable law.

  Additionally, Prescription Drug benefits are subject to quantity level limits as conveyed by the Food and Drug Administration ("FDA") or the HMO's Pharmacy and Therapeutics Committee.

  The HMO, for all Prescription Drug benefits, requires Preapproval of a small number of drugs approved by the FDA for use in specific medical conditions. Where Preapproval or quantity limits are imposed, your Physician may request an exception for coverage by

providing documentation of Medical Necessity. The Member may obtain information about how to request an exception by calling Customer Service at the phone number on the ID Card.

You, or your Physician acting on your behalf, may appeal any denial of benefits or application of higher Copayments through the Complaint And Grievance Appeal Process described later in this Agreement.

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

  Decision Support also includes the availability of general health information, personal health coaching, PCP's and treating Physician's information, or other programs to assist in health care decisions.

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

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

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

- **Information About Our Utilization Review Process And Criteria**

  Utilization Review Process:
  Two conditions of the HMO's and its affiliates' benefit plan are that in order for a health care service to be covered or payable, the service must be (1) eligible for coverage under the benefit plan and (2) Medically Necessary. To assist the HMO in making

coverage determinations for certain requested health care services, the HMO uses established HMO Medical Policies and medical guidelines based on clinically credible evidence to determine the Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Member's benefit plan is called utilization review.

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

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

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

The HMO's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing Physicians with direct access to HMO plan Medical Directors to discuss coverage of a case. The nurses, Medical Directors, other Professional Providers, and independent medical consultants who perform utilization review services are not compensated or given incentives based on their coverage review decisions. Medical Directors and nurses are salaried, and

contracted external Physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The HMO does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

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

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

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

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

- hysterectomy
- nasal Surgery procedures
- potentially cosmetic or Experimental/Investigative services

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

Retrospective Review:
Retrospective review occurs after services have been provided. This may be for a

variety of reasons, including the HMO not being notified of a Member's inpatient admission until after discharge or where medical charts are unavailable at the time of a required concurrent review. Certain services are only reviewed on a retrospective basis.

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

Discharge Planning:
Discharge planning is performed during an inpatient admission and is used to identify and coordinate a Member's needs and benefit plan coverage following the Inpatient Stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves the HMO's authorization of post-Hospital Covered Services and identifying and referring Members to Disease Management or Case Management benefits.

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

CLINICAL CRITERIA, GUIDELINES AND RESOURCES

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

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

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

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

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

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

The HMO's Medical Polices may be applied for Covered Services including, but not limited to the following:

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

The HMO's Internally Developed Guidelines:
These are a set of guidelines developed specifically by the HMO, as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting the HMO's Medical Policies for benefit plan coverage.

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

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

Utilization Review and Criteria for Behavioral Health Services
Utilization Review activities for behavioral health services (mental health and Alcohol Or Drug Abuse And Dependency services) have been delegated by the HMO to its contracted behavioral health management company which administers the behavioral health benefits for the majority of the HMO's Members.

SECTION ACC – ACCESS TO PRIMARY, SPECIALIST AND HOSPITAL CARE

DIRECT ACCESS TO CERTAIN CARE

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

A. Emergency Services
B. Care from a participating obstetrical/gynecological Specialist
C. Mammograms
D. Mental Health Care, Serious Mental Illness Health Care and Alcohol Or Drug Abuse And Dependency treatment
E. Inpatient Hospital Services that require Preapproval. This does not include a maternity Inpatient Stay
F. Dialysis services performed in a Participating Facility Provider or by a Participating Professional Provider
G. Nutrition Counseling for Weight Management
H. Diabetic Education Program

SELECTION OF A PRIMARY CARE PHYSICIAN

A. Prior to the time a Member's coverage becomes effective in accordance with the provisions of this Agreement, the Member must choose a Primary Care Physician from whom the Member wishes to receive Covered Services under this Agreement. If the Member is a minor or otherwise incapable of selecting a PCP, the Subscriber or legal guardian should select a PCP on the Member's behalf.

   At the new Member's option and subject to the Non-Participating Provider's agreement to certain terms and conditions, the Member may continue an ongoing course of treatment with a Non-Participating Provider for a period of up to sixty (60) days from the Member's Effective Date of Coverage (See Continuity of Care provision below).

B. If a Member fails either to select a Primary Care Physician or complete a Continuity of Care form within thirty (30) days of membership, the HMO reserves the right to assign a Member to a Primary Care Physician subject to the Member's right to change Primary Care Physicians as described below.

HOW TO OBTAIN A SPECIALIST REFERRAL

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

If, except for services listed under the Direct Access To Certain Care provision, your Primary Care Physician refers you to a Referred Specialist or facility just follow these steps:

- Your Primary Care Physician will supply an electronic form which indicates the services authorized.
- Your Referral is valid for ninety (90) days from issue date as long as you are a Member.
- You can give this form to the Referred Specialist or facility or it can be sent electronically to the Referred Specialist or facility **before** the services are performed. Only services authorized on the Referral form will be covered.
- Any additional Medically Necessary treatment recommended by the Referred Specialist

beyond the ninety (90) days from the date of issue of the initial Referral will require another electronic Referral from your Primary Care Physician.
- You must be an enrolled Member at the time you receive services from a Referred Specialist or Non-Participating Provider in order for services to be covered.

See the **Preapproval for Non-Participating Providers** section of this Subscriber Agreement for information regarding services provided by Non-Participating Providers.

HOW TO OBTAIN A STANDING REFERRAL

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

Follow these steps to initiate your Standing Referral request.

A. Call Customer Service at the telephone number shown on your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Care Management and Coordination to obtain a “Standing Referral Request” form.)
B. A “Standing Referral Request” form will be mailed or faxed to the requestor.
C. You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to Care Management and Coordination.

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

If the Standing Referral is Approved

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

If the Standing Referral is Denied

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

DESIGNATING A REFERRED SPECIALIST AS YOUR PRIMARY CARE PHYSICIAN

If you have a life-threatening, degenerative or disabling disease or condition, you may have a Referred Specialist named to provide and coordinate both your primary and specialty care. The Referred Specialist will be a Physician with clinical expertise in treating your disease or

condition. It is required that the Referred Specialist agree to meet the plan's requirements to function as a Primary Care Physician.

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

A. Call Customer Service at the telephone number shown on your ID Card. (Or, you may ask your Primary Care Physician to call Provider Services or Care Management and Coordination to initiate the request.)
B. A "Request for Specialist to Coordinate All Care" form will be mailed or faxed to the requestor.
C. You must complete a part of the form and your Primary Care Physician will complete the clinical part. Your Primary Care Physician will then send the form to Care Management and Coordination.
D. The Medical Director will speak directly with your Primary Care Physician and the selected Referred Specialist to apprise all parties of the primary services that the Referred Specialist must be able to provide in order to be designated as a Member's Primary Care Physician. If Care Management and Coordination approves the request, it will be sent to the Provider Service Area. That area will confirm that the Referred Specialist meets the same credentialing standards that apply to Primary Care Physicians. (At the same time, you will be given a Standing Referral to see the Referred Specialist.)

If the Referred Specialist as Primary Care Physician Request is Approved

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

If the Referred Specialist as Primary Care Physician Request is Denied

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

CHANGING YOUR PRIMARY CARE PHYSICIAN

If a Member wishes to transfer to a different Primary Care Physician, a request can be made at any time, by:

A. submitting in writing, calling the telephone number shown on the back of the Member ID Card, or using the IBX Mobile app to the HMO's Customer Service Department, or
B. logging into the website at www.ibxpress.com and selecting Account Settings and Member Information.

The change will become effective on the earlier of:

- 14 days after the request is received (includes weekends), or
- the first day of the upcoming month.

Exceptions: However, changes will take effect on the first of the current month:

a. when the Member did not make a PCP selection at the time of enrollment, or
b. if the Member's PCP is no longer a Participating Provider.

If the participating status of the Member's Primary Care Physician changes, the Member will be notified in order to select another Primary Care Physician.

The Member must remember to have their medical records transferred to their new Primary Care Physician.

CHANGING YOUR REFERRED SPECIALIST

The Member may change the Referred Specialist to whom the Member has been Referred by a Primary Care Physician or for whom the Member has a Standing Referral. To do so, the Member should ask the Primary Care Physician to recommend another Referred Specialist before services are performed. Or, the Member may call Customer Service at the telephone number shown on the ID Card. Only services authorized on the Referral form will be covered.

PROVIDER DIRECTORY

A Provider Directory is made available to Members. It includes a listing of Hospitals and Primary Care Physicians and Referred Specialists by location, telephone numbers and Hospital affiliation. The Directory also includes a foreign language index to help Members to locate a Provider who is fluent in a particular language. The Directory also will indicate whether the Physician is accepting new patients.

CONTINUITY OF CARE

A. You have the option, if your Physician agrees to be bound by certain terms and conditions as required by the HMO, of continuing an ongoing course of treatment with that Physician. This continuation of care shall be offered through the current period of active treatment for an acute condition or through the acute phase of a chronic condition or for up to ninety (90) calendar days from the notice that the status of your Physician has changed or your Effective Date of Coverage when:
   1. Your Physician is no longer a Participating Provider because the HMO terminates its contract with that Physician, for reasons other than cause; or

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

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

C. Follow these steps to initiate your continuity of care:
   1. Call Customer Service at the number on your ID Card and ask for a "Request for Continuation of Treatment" form.
   2. The "Request for Continuation of Treatment" form will be mailed or faxed to you.
   3. You must complete the form and send it to Care Management and Coordination at the address that appears on the form.

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

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

PREAPPROVAL FOR NON-PARTICIPATING PROVIDERS

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

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

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

C. Obtained authorization from the HMO prior to receiving care. The HMO reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.

If the HMO approves the use of a Non-Participating Provider, you will not be responsible for the difference between the Provider's billed charges and the HMO's payment to the Provider but you will be responsible for applicable cost-sharing amounts. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

HOSPITAL ADMISSIONS

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

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

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

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

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

Should your Primary Care Physician or Participating Specialist agree with the HMO that

inpatient hospitalization services are no longer required, you will be notified in writing of this decision. Should you decide to remain hospitalized after this notification, the Hospital has the right to bill you after the date of the notification. You may appeal this decision through the Grievance Process.

RECOMMENDED PLAN OF TREATMENT

You agree, when joining the HMO, to receive care according to the recommendations of your Primary Care Physician. You have the right to give your informed consent before the start of any procedure or treatment. You also have the right to refuse any drugs, treatment or other procedure offered to you by the HMO Providers, and to be informed by your Physician of the medical consequences of your refusal of any drugs, treatment, or procedure. The HMO and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. The HMO will not be responsible for the costs of any alternative treatment that is not a Covered Service or determined to be not Medically Necessary for that condition. You may use the Grievance Procedure to have any denial of benefits reviewed, if you so desire.

SPECIAL CIRCUMSTANCES

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

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

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

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

MEMBER LIABILITY

Except when certain Copayments or other Limitations are specified in this Subscriber Agreement or Section SC - Schedule of Cost Sharing & Limitations, you are not liable for any charges for Covered Services when these services have been provided or Referred by your Primary Care Physician and you are eligible for such benefits on the date of service.

RIGHT TO RECOVER PAYMENTS MADE IN ERROR

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

SECTION ER – EMERGENCY, URGENT CARE, FOLLOW-UP CARE

WHAT ARE EMERGENCY SERVICES?

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

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

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

Emergency Services do not require a Referral for treatment from the Primary Care Physician.

Emergency Services Inside and Outside the Service Area

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

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

Note: For Emergency Care provided by certain Non-Participating Providers, for example, ambulance services, in accordance with applicable law, the HMO will reimburse the Non-Participating Provider at an in-network rate directly. In this instance the specified Non-Participating Provider will not bill the Member for amounts in excess of the HMO's payment for the Emergency Care. Payment for Emergency Services provided by Non-Participating Providers will be the greater of:

- The median of the amounts paid to Participating Providers for Emergency Services;
- The amount paid to Non-Participating Providers; or
- The amount paid by Medicare.

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

MEDICAL SCREENING EVALUATION

Medical Screening Evaluation services are Covered Services when performed in a Hospital emergency department to determine whether or not an Emergency exists.

WHAT IS URGENT CARE?

"Urgent Care" needs are for sudden illness or Accidental Injury that require prompt medical attention, but are not life-threatening and are not Emergency medical conditions, when your Primary Care Physician is unavailable. Examples of Urgent Care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not Preventive Care or Follow-up Care.

Urgent Care Inside Keystone's Service Area

If you are within the Service Area and you need Urgent Care, call your Primary Care Physician first. Your Primary Care Physician provides coverage 24 hours a day, 7 days a week for Urgent Care. Your Primary Care Physician, or the Physician covering for your Primary Care Physician, will arrange for appropriate treatment. Urgent Care services may also be accessed directly at an Urgent Care Center or Retail Clinic.

Urgent Care provided within the Service Area will be covered only when provided or Referred by your Primary Care Physician, or when provided at an Urgent Care Center or Retail Clinic without a Referral.

WHAT IS FOLLOW-UP CARE?

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

URGENT CARE AND FOLLOW-UP CARE OUTSIDE KEYSTONE'S SERVICE AREA – THE BLUECARD PROGRAM'S URGENT AND FOLLOW-UP CARE BENEFITS

Members have access to health care services when traveling outside of Keystone's Service Area. These services are available through the Blue Cross and Blue Shield Association's BlueCard Program. The length of time that the Member is outside the Service Area may affect: (1) the benefits the Member receives; (2) the Member's portion of cost-sharing; and (3) the procedures to be followed to obtain care covered under the HMO plan.

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

Urgent Care Benefits When Traveling Outside Keystone's Service Area

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

Urgent Care required during a temporary absence (less than ninety (90) consecutive days) from Keystone's Service Area will be covered when:

- The Member calls 1-800-810-BLUE (TTY: 711). This number is available twenty-four (24) hours a day, seven (7) days a week. The Member will be given the names, addresses and phone numbers of three BlueCard Providers. The BlueCard Program has some international locations. When the Member calls, he or she will be asked whether he or she is inside or outside of the United States.
- The Member decides which provider he or she will visit.
- The Member must call 1-800-227-3116 (TTY: 711) to get prior authorization for the service from the HMO.
- With the HMO's approval, the Member calls the provider to schedule an appointment.
- The BlueCard Provider confirms Member eligibility.
- The Member shows his or her ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of his or her visit.

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

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

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

- The Member is currently receiving urgent ongoing treatment for a condition.
- The Member plans to go out of Keystone's Service Area temporarily, and his or her Primary Care Physician recommends that the Member continue treatment.
- The Primary Care Physician calls 1-800-227-3116 (TTY: 711) to get prior authorization for the service from the HMO. If a BlueCard Provider has not been pre-selected for the Follow-Up Care, the Primary Care Physician or Member will be told to call 1-800-810-BLUE. (TTY: 711)
- The Primary Care Physician or Member will be given the names, addresses and phone

numbers of three BlueCard Providers.

- Upon deciding which BlueCard Provider will be visited, the Primary Care Physician or Member must inform the HMO by calling the number on the ID Card.
- The Member calls the BlueCard Provider to schedule an appointment.
- The BlueCard Provider confirms Member eligibility.
- The Member shows his or her ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of his or her visit.

CONTINUING CARE

Medically Necessary care provided by any Provider other than your Primary Care Physician will be covered, subject to Section CS – Description of Covered Services, Section EX - Exclusions, Section SC - Schedule of Cost Sharing & Limitations, and Preapproval requirements, only until you can, without medically harmful consequences, be transferred to the care of your Primary Care Physician or a Referred Specialist designated by your Primary Care Physician. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

All continuing care must be provided or Referred by your Primary Care Physician or coordinated through Customer Service.

AUTO OR WORK-RELATED ACCIDENTS

Motor Vehicle Accident

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

REMEMBER: For other than direct access Emergency and Urgent Care Services, the HMO will always be secondary to your auto insurance coverage. However, in order for services to be covered by the HMO as secondary, your care must be provided or Referred by your Primary Care Physician.

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

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

Work-Related Accident

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

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

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

Call Customer Service as soon as possible and advise us that you have been involved in a work-related accident. This information helps the HMO to coordinate your HMO benefits with coverage provided through your employer's Worker's Compensation coverage. Only services provided or Referred by your Primary Care Physician will be covered by the HMO.

SECTION GM – AWAY FROM HOME CARE PROGRAM® GUEST MEMBERSHIP BENEFITS

When Traveling Outside Keystone's Service Area For Longer Periods – The Away From Home Care Guest Membership Benefits

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

Who is Eligible to Register for Guest Membership Benefits?

You may register for Guest Membership Benefits when:

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

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

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

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

NOTE: Because your Primary Care Physician can give advice and provide recommendations about health care services that you may need while traveling, you are encouraged to receive routine or planned care prior to leaving home.

As a Guest Member, you must select a Primary Care Physician from the Host HMO's Primary Care Physician network. In order to receive Guest Membership Benefits, the Primary Care Physician in the Host HMO Service Area must provide or arrange for all of your Covered Services while you are a Guest Member. Neither Keystone nor the Host HMO will cover services you receive as a Guest Member that are not provided or arranged by the Primary Care Physician in the Host HMO Service Area and Preapproved by the Host HMO.

Registration in the Away From Home Care Program is available only through contracting HMOs in the Blue Cross and Blue Shield Association's HMO network. Information regarding the availability of Guest Membership Benefits may be obtained from the Away From Home Care Coordinator by calling Customer Service at the telephone number shown on the ID Card.

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

When the Member Does Not Use the BlueCard or Guest Membership Programs

If a Member has Out-of-Area Urgent Care or Emergency Services not provided as described above and provided by a Non-Participating Provider the Member should ask the Provider to submit the bill to the HMO. The Member should show his or her ID Card to the Provider for necessary information about the HMO plan. For direct billing, the Member should have the Provider mail the bill. If direct billing cannot be arranged, the Member should send the HMO a letter explaining the reason care was needed and an original itemized bill to:

Keystone Health Plan East
P.O. Box 69353
Harrisburg, PA 17106-9353

NOTE: It is your responsibility to forward to Keystone any bill you receive for Emergency Services or Out-of-Area Urgent Care provided by a Non-Participating Provider.

SECTION MR – YOUR MEMBERSHIP RIGHTS AND RESPONSIBILITIES

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

Your Membership Rights

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

- The Member has the right to information about the health plan, its benefits, policies, participating practitioners/Providers and Members' rights and responsibilities. Written information that is provided to the Member will be readable and easily understood.

- The Member has the right to be treated with respect, and recognition of their dignity and right to privacy.

- The Member has the right to participate in decision making regarding his/her health care. This right includes candid discussions of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage.

- The Member has a right to voice Complaints or appeals about the health plan or care provided, and to receive a timely response.

- The Member has the right to make recommendations regarding the organization's Member rights and responsibilities policies by contacting the Customer Service Department in writing.

- The Member has the right to choose practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners.

- The Member has the right to confidential treatment of medical information. The Member also has the right to have access to his/her medical record in accordance with applicable state and federal law.

- The Member has the right to reasonable access to medical services.

- The Member has the right to receive health care services without discrimination:
  - based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity;
  - for medically necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
  - based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
  - related to gender transition if such denial or limitation results in discriminating against a transgender individual.

- The Member has the right to formulate advance directives. The plan will provide information concerning advance directives to Members and practitioners and will support Members through its medical record keeping policies.

Your Membership Responsibilities

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

- Members have the responsibility to communicate, to the extent possible, information the plans, participating practitioners and Providers need in order to care for the Member.

- Members have the responsibility to follow the plans and instructions for care that they have agreed on with their practitioners. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.

- Members have the responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

- Members have the responsibility to review all benefit and membership materials carefully and to follow the regulations pertaining to the health plan.

- Members have the responsibility to ask questions to assure understanding of the explanations and instructions given.

- Members have the responsibility to treat others with the same respect and courtesy expected for oneself.

- Members have the responsibility to keep scheduled appointments or to give adequate notice of delay or cancellation.

- The Member may be financially responsible for the cost of any service or supply, received after the date the Member's coverage is terminated under this plan.

SECTION APP – COMPLAINT AND GRIEVANCE APPEAL PROCESS

GENERAL INFORMATION ABOUT THE APPEAL PROCESSES

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

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

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

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

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

  Member Appeals Department
  P.O. Box 41820
  Philadelphia, PA 19101-1820
  Toll Free: 1-888-671-5276 (TTY: 711)
  Fax: 1-888-671-5274

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

If your Provider files an appeal on your behalf, the HMO will verify that the Provider is acting as your appeal representative with your permission by obtaining valid authorization forms. A Member who authorizes the filing of an appeal by a Provider cannot file a separate appeal.

Information for the Appeal Review:

- **How to File and Get Assistance** - Appeals may be submitted by you or your appeal representative with your authorization by following the steps outlined below in the descriptions of the Member Complaint Appeal Process and Member Grievance Appeal Process. At any time during these appeal processes, you may request the help of an HMO employee in preparing or presenting your appeal; this assistance will be available at no charge. Please note that the HMO employee designated to assist you will not have participated in the previous decision to deny coverage for the issue in dispute and will not be a subordinate of the original reviewer.

- **Full and Fair Review** - The Member or designee is entitled to a full and fair review. Specifically, at all appeal levels the designee may submit additional information pertaining to the case, to the HMO. The Member or designee may specify the remedy or corrective action being sought. At the Member's request, the HMO will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The HMO will automatically provide the Member or designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or designee at no charge.

- **Advanced Notice** - The HMO will not terminate or reduce an on-going course of treatment without providing the Member or designee with advance notice and the opportunity for advanced review.

- **Urgent Care** - An urgent expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Members with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

- **Changes in Your Appeals Processes** - Please note that the Members appeal processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Member appeals process, or to reflect other decisions regarding the administration of Members appeal processes for this HMO Program.

- **Appeal Decision Letters** - If the Member's appeal request is not granted in full, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Member may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Member or designee may request in writing, at no charge, the name(s) of the individual(s) who participated in the decision to uphold the denial.

- **Appeal Classifications.** The two classifications of appeals - Complaints and Grievances - established by Pennsylvania state laws and regulations are described in detail in separate sections below. A Grievance appeal may be filed when the denial of a covered service is based primarily on Medical Necessity. A Complaint appeal may be filed to challenge a denial based on a contract limitation or to complain about other aspects of health plan policies or operations.

You may question the classification of your appeal as a Complaint or Grievance by contacting the HMO's Member Appeals Department or your assigned appeals specialist at the address and telephone number shown above or by contacting the Pennsylvania Department of Health or the Pennsylvania Insurance Department at:

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health and Welfare Bldg.
625 Forster Street
Harrisburg, PA 17120-0701
1-717-787-5193 (TTY: 711)
Fax: 1-717-705-0947

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388 (TTY: 711)
Fax: 1-717-787-8585

Appeals are also subject to the following classifications that affect the time available to conduct the appeal review:

A **pre-service** appeal is any appeal for benefits with a coverage requirement that Preapproval or precertification by the HMO must be obtained before medical care and services are received. For issues pertaining to medical judgment, a maximum of **thirty (30) days** is available for the one internal standard pre-service appeal.

A **post-service** appeal includes any appeal regarding benefits for medical care or services that a Member has already received. A maximum of **sixty (60) days** is available for the one internal level of appeal available for issues pertaining to medical judgment or rescissions of coverage. For all Complaints, a maximum of **thirty (30) days** is available for each of the two (2) levels of internal review available for a standard post-service Complaint.

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

MEMBER COMPLAINT APPEAL PROCESS

Informal Member Complaint Process

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

If you have a concern, you should call Customer Service at the telephone number listed on your ID Card, or write to:

Manager of Customer Service
Keystone Health Plan East, Inc.
P.O. Box 8339
Philadelphia, PA 19101-8339

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

Formal Member Complaint Appeal Process

You may file a formal Complaint appeal regarding an unresolved dispute or objection regarding coverage, including this HMO program's exclusions and non-covered services, coverage limitations, participating or Non-Participating Provider status, cost sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions), or the operations or management policies of the HMO. The Complaint process consists of two (2) internal levels of review by the HMO, and one external level of review by the Pennsylvania Department of Health or the Pennsylvania Insurance Department. There is also an internal expedited Complaint appeal process in the event your condition involves an urgent issue.

Internal Complaint Appeals

Standard Internal First Level Complaint Appeal

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

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276 (TTY: 711)
Fax: 1-888-671-5274

The HMO will acknowledge receipt of your Complaint appeal in writing within **five (5) business days** of receipt of the request.

The First Level Complaint Committee will complete its review of your standard Complaint appeal within: (1) **fifteen (15) calendar days** from receipt of a pre-service appeal; and, (2) **thirty (30) calendar days** from receipt of a post-service appeal.

The First Level Complaint Committee is composed of one (1) HMO employee who has had no previous involvement with your case and who is not subordinate to the person who made the original determination. You will be sent their decision in writing within the timeframes noted above. If your Complaint appeal is denied, the decision letter states: (1) the specific reason for the decision; (2) this HMO Program's provision on which the decision is made and instructions on how to access the provision; and, (3) how to appeal to the next level if you are not satisfied with the decision.

Standard Internal Second Level Complaint Appeal

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

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

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

The Second Level Complaint Committee meets and renders a decision on your standard Complaint appeal within: (1) fifteen (15) calendar days from receipt of a pre-service appeal; and, (2) thirty (30) calendar days from receipt of a post-service appeal.

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

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

videotape the committee proceedings.

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

Standard Internal Expedited Complaint Appeals

If your case involves an urgent issue, then you or your Physician may ask to have your case reviewed in a faster manner, as an internal expedited Complaint. There is only one internal level of appeal review for an expedited Complaint appeal.

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

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

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

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

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

The decision is final unless you choose to appeal to the Pennsylvania Insurance Department or the Pennsylvania Department of Health as described in the decision letter. (See also "External Complaint Appeals" below.)

External Complaint Reviews

Standard External and Expedited Complaint Reviews

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

Pennsylvania Department of Health
Bureau of Managed Care
Room 912, Health and Welfare Bldg.
625 Forster Street
Harrisburg, PA 17120-0701
1-717-787-5193 (TTY: 711)
Fax: 1-717-705-0947

Pennsylvania Insurance Department
Bureau of Consumer Services
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388 (TTY: 711)
Fax: 1-717-787-8585

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

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

GRIEVANCE/RECISSIONS of COVERAGE APPEAL PROCESS

Formal Member Grievance Appeal Process for Decisions Based On Medical Necessity or Rescissions of Coverage

Members may file a formal Grievance/appeal of a decision by the HMO regarding a Covered Service that was denied or limited based primarily on Medical Necessity, the cosmetic or Experimental/Investigative exclusions, or other grounds that rely on a medical or clinical judgment, and for issues pertaining to rescissions of coverage (except for non-payment of premiums or contributions).

This appeal process consists of one (1) internal review by the HMO and an external review for decisions based on medical judgment or rescissions of coverage (except for non-payment of premiums or contributions) and is via the federally administered private accredited Independent Review Organization (IRO) process as required by Health Care Reform.

There is also an internal and external expedited Grievance/appeal process in the event your condition involves an urgent issue.

Internal Grievance Appeals

Internal First Level Standard Grievance/Appeals

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

Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19101-1820
Toll Free: 1-888-671-5276 (TTY: 711)
Fax: 1-888-671-5274

The HMO will acknowledge receipt of your Grievance/appeal in writing within **five (5) business days** of receipt of the request.

Your one level of internal appeal is reviewed by a committee for which a plan medical director is the decision-maker. This individual has had no previous involvement in the case, is not a subordinate of the person who made the original determination, and holds an active unrestricted license to practice medicine. Additionally, the plan medical director is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist or "same or similar specialty Physician" is a licensed Physician or Psychologist who: is in the same or similar specialty as typically manages the care under review.

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

The appeal committee completes its review of your standard appeal within: **thirty (30) calendar days** from receipt of a pre-service appeal; and, (2) **sixty (60) calendar days** from receipt of a post-service appeal.

You will be sent the committee's decision on your internal appeal in writing within the timeframes noted above. If your Grievance appeal is denied, the decision letter states: (1) the specific reason for the denial; (2) this HMO program's provision on which the decision is made and instructions on how to access the provision; and, (3) how to appeal to the external review if you are not satisfied with the decision.

Internal Expedited Grievance Appeals

If your case involves an urgent medical condition, then you or your Physician may ask to have your case reviewed in a faster manner, as an expedited Grievance. There is only one internal level of appeal review for an expedited Grievance appeal.

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

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

The Expedited Grievance Committee has the same composition as a Second Level Grievance Committee for a standard Grievance appeal.

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

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

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

External Grievance Appeal Reviews

Issues involving medical judgment (Grievance) or a rescission of coverage (except for non-payment of premiums or contributions) are coordinated by the plan in full compliance with the federally administered private accredited Independent Review Organization (IRO) process as required by the Affordable Care Act. The two types of external Grievance appeals—standard and expedited—are described below. Members are not required to pay any of the costs associated with the external standard or expedited Grievance appeal review.

Standard External Review Process

The Member/designee may request an external review of a Grievance/rescission of coverage by calling or writing to the plan within one hundred and eighty (180) calendar days of receipt of the internal appeal decision letter.

The Member/designee is sent written confirmation of receipt of his/her external review request from the plan within five (5) business days of receipt of the request. This confirmation includes the name and contact information for the plan staff person assigned to facilitate the processing of the Member's external review and information on the IRO assignment. Information on the IRO assignment identifies the assigned IRO by name and states the qualifications of the individual who reviews the appeal.

The IRO assigned to the external review request is a different organization than the one that supplied the same/or similar specialty review for the internal appeal process. The individual appointed by the IRO to review the Member's external review has not been previously involved in any aspect of decision-making on the appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the plan, with the Member, or the designee. The plan's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the plan assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal appeal process, nor a subordinate of that person. If the Member/designee feels that a conflict exists, he/she should call or write the contact person listed on the acknowledgement letter from the plan no later than two (2) business days from receipt of the acknowledgment letter from the plan.

The plan sends the Member/designee and the IRO a letter listing all documents forwarded to the IRO. These documents include copies of all information submitted for the internal appeal process, as well as any additional information that the Member/designee or the plan may submit. If the Member wishes to submit additional information for consideration by the IRO, he should do so within ten (10) calendar days of the Member's request for an external review.

The plan does not interfere with the IRO's proceedings or appeals decisions. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal appeal process.

The IRO makes its final decision within forty five (45) calendar days of receipt of the Member's request and simultaneously issues its decision in writing to the Member or designee and to the plan. The established deadline for a decision from the IRO may only be exceeded for good cause when a reasonable delay for a specific period is acceptable to the Member or designee. If the decision of the IRO is that the services are covered, the plan authorizes the service and/or pays the claims. The Member/designee is notified in writing of the time frame and procedure for claim payment or approval of the service in the event of an overturn of the plan's earlier determination. The plan implements the IRO's decision within the time period, if any, specified by the IRO.

The external decision is binding on the plan.

Urgent External Expedited Review Process

The Member/designee may request an urgent external medical judgment/Grievance or rescission of coverage review for urgent/expedited situations through an IRO. The Member or designee is not required to pay any of the costs associated with the external review.

With the exception of time frames, the urgent/expedited external review mirrors the process described above under the external standard review.

Within twenty-four (24) hours of receipt of the Member's request for an urgent/expedited review, the plan confirms the request and faxes the request to the assigned IRO. During this time, the plan also forwards to the IRO, by secure electronic transmission or overnight delivery, all information submitted in the internal appeal process and any additional information that the Member, designee, or the plan wishes to submit to the IRO.

The IRO makes a decision and simultaneously notifies the Member/designee and the plan in writing within seventy two (72) hours of receipt of all relevant documentation. The decision letter identifies the assigned IRO by name and states the qualifications of the individual that the IRO appoints to review the external review.

If the decision of the IRO is that the services are eligible, the plan authorizes the service and/or pays the claims. The Member is notified in writing of the time frame and procedure for claim payment and/or approval of the service in the event of an overturn of the plan's earlier determination. The plan implements the IRO's decision within the time period, if any, specified by the IRO.

The external decision is binding on the plan.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal you may have the right to bring civil action under Section 502(a) of the Act. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (TTY: 711)). Additionally, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1326 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388 (TTY: 711)
www.insurance.pa.gov

If your Carrier fails to "strictly adhere" to the internal appeals process, you may initiate an external review or file appropriate legal action under state law or ERISA unless:

- Violation was de minimis (minimal).
- Did not cause (or likely to cause) prejudice or harm to the claimant.
- Was for good cause or due to matters beyond the control of the insurer/plan.
- In the context of a good faith exchange of information with the claimant.
- Not part of a pattern or practice of violations.

SECTION COB – COORDINATION OF BENEFITS

All benefits, except the Vision Care and Pediatric Dental Services benefits, provided under this Agreement are subject to this provision, and will not be increased by virtue of this provision.

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

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

COORDINATION OF BENEFITS ADMINISTRATION

A. With Other Health Care Plans
Except as otherwise stated, all benefits in the Agreement are subject to the following provisions of this paragraph. The HMO will provide access to Covered Services first and determine liability later.

1. Definitions
In addition to the terms defined in Section DE – Definitions, the following definitions apply to this subsection:

a. "Other Contract" means any individual coverage or group arrangement providing health care benefits or services through:
(i) group blanket or franchise insurance coverage, except that it shall not mean any blanket school/student accident coverage or a hospital indemnity plan of one hundred dollars ($100) per day or less.
(ii) Blue Cross, Blue Shield, group or individual practice plan, health maintenance organization and other prepayment coverage;
(iii) Coverage under labor-management trustee plans, union welfare plans, employer organizations plans, or employee benefit organization plans; and
(iv) Coverage under any tax supported or government program to the extent permitted by law.

"Other Contract" shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take the benefits or services of Other Contracts into consideration in determining its benefits and that portion which does not.

b. “Allowable Benefit” as used in this subsection, means the total charge for a service or supply specified in this Agreement for which benefits will be provided, to the extent that such service or supply is covered by this and/or the Other Contract.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

When benefits are reduced under the Primary Contract because a Member does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Benefit.

c. “Dependent” means, for any Other Contract, any person who qualifies as a Dependent under that Other Contract.

d. “Primary/Secondary Contract” means the order of benefit determination rules state whether this Agreement is a Primary Contract or Secondary Contract.
   (i) When this Agreement is a Primary Contract, its benefits are determined before those of the Other Contract and without considering the Other Contract’s benefits.
   (ii) When this Agreement is a Secondary Contract, its benefits are determined after those of the Other Contract and may be reduced because of the Other Contracts’ benefits.
   (iii) When there are more than two Other Contracts covering the person, this Agreement may be a Primary Contract as to one or more Other Contracts, and may be a Secondary Contract as to a different contract or contracts.

2. Effects on Benefits
   a. This subsection shall apply in determining the benefits of this Agreement if, for the Covered Services received, the sum of the benefits payable under this Agreement and the benefits payable under Other Contracts would exceed the total Allowable Benefits.

   b. Except as provided in item (c) of this subparagraph, the benefits payable under this Agreement for Covered Services received will be reduced so that the sum of the reduced benefits and the benefits payable for Covered Services under Other Contracts would not exceed the total Allowable Benefits. Benefits payable under Other Contracts include the benefits that would have been payable had claim been made.

   c. If,
      (i) an Other Contract contains a provision coordinating its benefits with those of this agreement and its rules require the benefits of this Agreement to be determined first, and
      (ii) the rules set forth in Subparagraph (d), below, require the benefits of this Agreement to be determined first, then the benefits of the Other Contract will be disregarded in determining the benefits under this Agreement.

   d. This Agreement determines its order of benefits using the first of the following rules which applies

(i) The benefits of a contract which covers the person as other than a Dependent shall be determined first (Primary Contract).

(ii) In the case of a Dependent child, the following rules apply:

(aa) **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Items (bb) and (cc), when this Agreement and an Other Contract cover the same child as a Dependent of different persons, called parents:

- the benefits of the contract of the parent whose birthday (excluding year of birth) falls earlier in a year shall be determined before those of the contract the parent whose birthday falls later in that year; but,

- if both parents have the same birthday, the benefits of the contract which covered the parent longer are determined before those of the contract which covered the other parent for a shorter period of time.

However, if the Other Contract does not have the rule described in item (aa) above, but instead has a rule based upon the gender of the parent, and if, as a result, the contracts do not agree on the order of benefits, the rule in the Other Contract will determine the order of benefits.

(bb) **Dependent Child/Separated or Divorced Parents.** If two (2) or more contracts cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- first, the contract of the parent with custody of the child;
- then, the contract of the spouse of the parent with custody of the child;
- finally, the contract of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the contract of that parent has actual knowledge of those terms, the benefits of that contract are determined first (Primary Contract). This paragraph does not apply to any claim determination period during which any benefits are actually paid or provided before the entity has that actual knowledge.

(cc) if the specific terms of a 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 contracts covering the child shall follow the order of benefit determination rules outlined in subparagraph (d)(ii)(aa), Dependent Child/Parents Not Separated or Divorced.

(iii) When rules in items (i) and (ii) above do not establish an order of benefit determination, the benefits of the contract which has covered the person for the longest period of time shall be determined first (Primary Contract) provided that:

(aa) the benefits of the contract covering the person as an employee who is neither laid-off nor retired, or as a Dependent of such person, are determined before the benefits of the contract covering the person as a laid-off or retired employee or as a Dependent of such person.

(bb) if the Other Contract does not have this rule, and if, as a result, the contracts do not agree on the order of benefits, then this rule is disregarded.

e. If an Other Contract does not contain provisions establishing the same order of benefit determination rules, the benefits under that contract/agreement will be determined before the benefits under this Agreement. This Agreement will be the Secondary Contract.

3. Facility of Payment
Whenever payments should have been made under this Agreement in accordance with this subsection, but the payments have been made under any Other Contract, the HMO has the right to pay to any organization that has made such payments any amounts it determines to be warranted to satisfy the intent of this subsection. Amounts so paid shall be deemed to be benefits paid under this Agreement and, to the extent of the payments for Covered Services, the HMO shall be fully discharged from liability under this Agreement.

4. Right of Recovery
a. Whenever payments have been made by the HMO for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Subsection, irrespective of to whom paid, the HMO shall have the right to recover the excess from among the following, as the HMO shall determine: any person to or for whom such payments were made, any insurance company, or any other organization.

b. The Member shall, upon reasonable request, execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure the HMO’s right to recover the excess payments.

5. Determination of Other Contracts
The HMO shall not be required to determine the existence of any Other Contract or amount of benefits payable under any Other Contract except this Agreement, and the payment of benefits under this Agreement shall be affected by the benefits payable under any and all Other Contracts only to the extent that the HMO is furnished with information relative to such Other Contract by the Member, or any other insurance company or organization or person.

B. Worker's Compensation
The benefits under this Agreement for Members eligible for Worker's Compensation are not designed to duplicate any benefit to which such Members are eligible under the Worker's Compensation Law. All sums payable pursuant to Worker's Compensation for services provided hereunder to Members are payable to and retained by the HMO. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

C. Medicare
Except as otherwise provided by applicable federal law, the benefits under this Agreement for Members age sixty-five (65) and older, or Members otherwise eligible for Medicare payments, do not duplicate any benefit to which such Members are eligible under the Medicare Act, including Part B of such Act. For working Members over age sixty five (65), primacy will be determined in accordance with TEFRA or existing regulations regarding Medicare reimbursement.

D. Member's Cooperation
Each Member shall complete and submit to the HMO such consents, releases, assignments and other documents as may be required by the HMO in order to determine the HMO's liability and to obtain or assure reimbursement under any other health plan, including Medicare or Worker's Compensation. Any Member who fails to so cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible primary payor) will be responsible for charges Incurred for services rendered.

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, you agree that the HMO has the right to enforce subrogation and reimbursement rights in accordance with applicable state and federal law. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to you for an injury or illness. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

Subrogation Rights

Subrogation rights arise when the HMO pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The HMO is subrogated to the Member's right to recover from the Responsible Third Party. This means that the HMO "stands in your shoes" - and assumes your right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the HMO has reimbursed you for medical expenses or paid medical expenses on your behalf. The right to pursue a subrogation claim is not contingent upon whether or not you pursue the Responsible Third Party for any recovery.

Reimbursement Rights

If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the HMO for all medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party to the extent permitted by law. The HMO has the right to pursue recovery of the full reimbursement amount.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage

or pain and suffering).

- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The HMO will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the HMO agrees to do so in writing.
- In addition to any Coordination of Benefits rules described in this Contract, the benefits paid by the HMO will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The HMO has the right to pursue recovery of the full reimbursement amount of the medical benefits paid without regard to any claim of fault on your part.

Obligations of Member

- Immediately notify the HMO or its designee in writing if you assert a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the HMO or its designee in writing whenever a Responsible Third Party contacts you or your representative - or you or your representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until you receive written authorization from the HMO or its delegated representative.
- Fully cooperate with the HMO and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the HMO's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the HMO or its designated representative promptly, if appropriate, out of the amounts recovered from the Responsible Third Party whether the funds are received by court judgment, settlement or otherwise from a Responsible Third Party.

  All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

SECTION CON - CONVERSION

For Members currently enrolled under a family Agreement, this conversion privilege is available to the surviving Dependents in the event of the Subscriber's death, to a spouse when divorced from the Subscriber, and to a child who ceases to be an eligible Dependent due to attaining the Dependent Limiting Age for Dependents.

If a Member becomes eligible for Medicare Part A and Part B, the Member shall have the right at that time to convert to such program as may then be available in conjunction with the governmental programs.

SECTION PR – ADDITIONAL INFORMATION ABOUT HOW WE REIMBURSE PROVIDERS

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

Professional Providers:

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

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

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

Institutional Providers:

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

For most outpatient and Emergency Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient Covered Services (e.g., lab and radiology) that includes both the facility

and Physician payment. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various Covered Services.

Some Hospitals participate in a quality incentive program. The program provides increased reimbursement to these Hospitals when they meet specific quality and other criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by The Leap Frog Group, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ) and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic submissions. This incentive program is expected to evolve over time.

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

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

Integrated Delivery Systems (Pennsylvania only): In a few instances, we have global payment arrangements with integrated Hospital/Physician organizations called Integrated Delivery Systems (IDS). In these cases the IDS provides or arranges for some of the Hospital, Physician and ancillary Covered Services provided to some of our Members who select PCPs which are employed by or participate with the IDS. The IDS is paid a global fee to cover all such Covered Services, whether provided by the IDS or other Providers. These IDSs are therefore "at risk" for the cost of these Covered Services. Some of these IDSs may provide incentives to their IDS-affiliated Professional Providers for meeting certain quality, service or other performance standards.

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

A Hospital-Based Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of the HMO's payment to the Hospital-Based Providers (i.e., "balance billing"). You are not liable for any balance billing charges for Covered Services provided by a Hospital-Based Provider. Your out-of-pocket costs are limited to applicable Copayments. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Physician Group Practices and Physician Associations: Certain Physician group practices and independent Physician associations (IPAs) employ or contract with individual Physicians to provide medical Covered Services. These groups are paid as outlined above. These groups may pay their affiliated Physicians a salary and/or provide incentives based on production, quality, service, or other performance standards. In Pennsylvania, we have entered into a joint venture with an IPA. This IPA is paid a global fee to cover the cost of all Covered Services, including Hospital, professional and ancillary Covered Services provided to Members who

choose a PCP in this IPA. This IPA is therefore “at risk” for the cost of these Covered Services. This IPA provides incentives to its affiliated Physicians for meeting certain quality, service and performance standards.

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

Mental Health/Alcohol Or Drug Abuse And Dependency: A Mental Health/Alcohol Or Drug Abuse And Dependency ("behavioral health") management company administers most of the behavioral health benefits, provides a network of Participating Behavior Specialists and processes the related claims. The behavioral health management company is paid a set dollar amount per Member per month (capitation) for each Member and is responsible for paying its contracted providers on a fee-for-service basis. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters.

A subsidiary of Independence Blue Cross has a less than one percent ownership interest in this behavioral health management company.

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

Participating Dentist: When treatments are performed by a Participating Dentist, in accordance with the Participating Dentist’s contract covered benefits will be paid directly to the Participating Dentist. Both the Member and the Dentist will be notified of benefits covered, the payment the Participating Dentist received and any out-of-pocket expenses. Payment will be based on the Maximum Allowable Charge the treating Participating Dentist has contracted to accept. Maximum Allowable Charges may vary depending on the geographical area of the dental office and in accordance with the Participating Dentist’s contract and the particular Participating Dentist rendering the service. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services rendered to Members. The Member shall be held harmless if, after receiving services from a Participating Dentist, such services are determined not Dentally Necessary.

Benefits for any services started prior to a Member’s Effective Date of Coverage are not covered. Multi-visit procedures are considered “started” when the teeth are irrevocably altered. For example, for crowns or fixed partial dentures, the procedure is started when the teeth are prepared and impressions are taken. Procedures started prior to the Member’s Effective Date of Coverage are the liability of the Member.

When an overpayment for benefits is made, the HMO has the right to recover the overpayment either from the Member or from the person or Dentist to whom it was paid. The overpayment will be recovered by requesting a refund. This recovery will follow any applicable state laws or regulations. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the HMO to be reimbursed.

This Agreement does not coordinate benefits with other dental plans.

SECTION CL – CLAIM PROCEDURES

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

NOTICE OF CLAIM

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

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

PROOF OF LOSS

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

CLAIM FORMS

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

SUBMISSION OF CLAIM FORMS

For Member-submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to the HMO at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Agreement.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:

A. Person or organization providing the service or supply
B. Type of service or supply
C. Date of service or supply
D. Amount charged
E. Name of patient

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

TIMELY PAYMENT OF CLAIMS

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

PHYSICAL EXAMINATIONS AND AUTOPSY

The HMO at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under this Agreement; and the HMO shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

PAYMENT OF CLAIMS

If any indemnity of this Agreement shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, the HMO may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by the HMO to be equitably entitled thereto. Any payment made by the HMO in good faith pursuant to this provision shall fully discharge the HMO to the extent of such payment.

SECTION EL – ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THE PLAN

ELIGIBILITY

A. **Eligible Subscriber**
An eligible Subscriber is an individual:

1. who is listed on the completed Application/Change Form and has been accepted for coverage by the HMO;
2. who resides in the Service Area; and
3. for whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling.

B. **Eligible Dependents**
An eligible Dependent is an individual who is listed on the Application/Change Form completed by the Subscriber and has been accepted for coverage by the HMO; who resides in the Service Area, unless otherwise provided in this section; for whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling; and who is:

1. The Subscriber's legal spouse (common-law marriages must be documented to the satisfaction of the HMO) or Domestic Partner; or
2. A child, including stepchild, legally adopted child, child placed for adoption, or natural child, of either the Subscriber, or the Subscriber's spouse or Domestic Partner, who is within the Limiting Age for Dependents as set forth in this Agreement, or a child for whom the Subscriber is legally required to provide health care coverage; or
3. A child who is within the Limiting Age for Dependents as set forth in this Agreement for whom the Subscriber, or the Subscriber's spouse or Domestic Partner, is a court appointed legal guardian; or
4. An unmarried child who is past the Limiting Age for Dependents will be eligible when they: (1) are a full-time student; (2) are eligible for coverage under this Agreement; and (3) prior to attaining the Limiting Age for Dependents and while a full-time student, were (a) a member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and were called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or (b) a member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

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

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

5. An unmarried child of either the Subscriber or the Subscriber's spouse, regardless of age, who, in the judgment of the HMO, is incapable of self-support due to a mental or physical handicap which commenced prior to the child's reaching the Limiting Age for Dependents under this Agreement and for which continuing justification may be required by the HMO; or

6. A child who is within the Limiting Age for Dependents as set forth in this Agreement, and who is a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from the Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The Limiting Age for Dependents will be applicable regardless of the status of the Medically Necessary leave of absence.

   When used throughout this Agreement, the following terms, when applied to Dependents, will have these meanings:

   The term “placement” will refer to a Dependent adopted child and the process or act of being placed for adoption.

RECORDS AND CHANGES OF MEMBER ELIGIBILITY

Certain changes in your life may affect your HMO coverage. Please notify us of any changes by contacting Customer Service at the telephone number on the back of your ID Card.

A. **Adding A Dependent Spouse**
A Dependent spouse shall be eligible for coverage under this Agreement provided that the Subscriber makes application to the HMO for addition of the Dependent spouse. The Effective Date of Coverage for such Dependent will be the first of the month following approval of the Application/Change Form by the HMO and timely payment of the appropriate rate.

If the newly acquired Dependent spouse is older than the Subscriber, the premium rate is based on the attained age of the Dependent spouse. Accordingly, the Dependent spouse may apply for another Agreement as an individual.

B. **Adding A Dependent Child**
A newborn child of a Member shall be entitled to benefits provided by this Agreement from the date of birth up to a maximum of thirty-one (31) days. To be eligible for Dependent coverage beyond the thirty-one (31) day period, the Applicant must enroll the newborn child as a Dependent within such thirty-one (31) days and make timely payment of the appropriate rate.

An adopted child of the Member shall be entitled to benefits provided by this Agreement from the date of placement for adoption up to a maximum of thirty-one (31) days. This coverage will be effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. To be eligible for Dependent coverage beyond the thirty-one (31) day period, the Applicant must enroll the adopted child as a Dependent within such thirty-one (31) days and make timely payment of the appropriate rate.

Except for a newborn child or adopted child, a newly acquired Dependent child shall be eligible for coverage under this Agreement provided that the Applicant makes Application to the HMO for addition of the Dependent. The Effective Date of Coverage for such child will be the first billing date following thirty (30) days after such Application is accepted by the HMO and timely payment of the appropriate rate has been made.

A Dependent child who is required to be covered under the terms of a qualified medical release or court order will be covered under this Agreement no later than thirty (30) days from receipt of the HMO of the court order, provided the HMO receives a completed Application and is accepted by the HMO.

C. **Death of Subscriber**

In the event of the death of the Subscriber, that coverage shall terminate at the end of the last period for which payment was accepted by the HMO. The spouse of the deceased Subscriber, if covered under the Agreement, shall become the "Applicant" under the Agreement and eligible Dependents will continue as the Subscriber's Dependents under the Agreement.

D. **Divorce of Dependent Spouse**

If a Dependent spouse is divorced from the Subscriber, coverage of such Dependent spouse under this Agreement shall terminate at the end of the last period for which payment was accepted by the HMO. The terminated spouse shall be entitled, by applying within sixty (60) days of such termination, to direct pay coverage of the same type for which the terminated spouse is then qualified at the rate then in effect.

E. **Dependent Child Attainment of Limiting Age for Dependents**

The eligibility of a Dependent child will terminate on Limiting Age for Dependents, except this limiting age of twenty six (26) does not apply to a full-time student who is eligible for coverage under this Agreement 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 an active duty for training for a period of 30 or more consecutive days; or (b) a member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch 76 (relates to Emergency Management Assistance Compact), for a period of thirty (30) or more days. The coverage for such child will terminate at the end of the last period for which premium was accepted by the HMO. No premium shall be accepted under this Agreement on behalf of a child for any period for which such child is not an eligible Dependent. However, in the event the HMO accepts premium for coverage beyond the date eligibility ends for such child, coverage for the child will be extended until the end of the then current paid date. Such child shall be entitled to direct pay coverage of the same or similar type for which he is then qualified by applying within sixty (60) days of such termination.

F. **Continuation of Incapacitated Child**

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Applicant for over half of that child's support, the Applicant may apply to the HMO to continue coverage of such child under this Agreement upon the terms and conditions set forth below. 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 disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review.

G. **Change of Status**
It shall be the responsibility of the Subscriber to notify the HMO within thirty (30) days of any changes which affect the eligibility of a Member for benefits under this Agreement.

All of the following changes require the Subscriber to notify the HMO:
- Name
- Address
- Status or number of Dependents
- Marital status
- Eligibility for Medicare

H. **Change of Residence**
It shall be the responsibility of the Subscriber to notify the HMO within thirty (30) days of any change of a Member's residence. If the Member moves to an area that is not within the Service Area, the Member's coverage may be terminated. In specified cases, Members who transfer their residence out of the Service Area may, with the approval of the HMO, continue their coverage under this Agreement. In order to continue coverage with the HMO, the Member is informed and must recognize that the benefits provided by the HMO under this Agreement are only available within the Service Area, except as otherwise stated under this Agreement.

You must notify the HMO of any changes in Dependent coverage in order to ensure coverage for all eligible family members.

EFFECTIVE DATE OF COVERAGE

This Agreement shall be effective from the date of this issuance, as that date appears on the records of the HMO for a term of twelve (12) consecutive months and annually thereafter upon payment and acceptance by the HMO of the premium due; and upon compliance with the terms and provisions of this Agreement, or any renewal thereof. The HMO will provide written confirmation of the Applicant's Effective Date of Coverage on the application form and the Schedule of Rates sent to the Applicant following acceptance by the HMO of the premium due.

TERMINATION OF COVERAGE

The HMO may terminate this Agreement as follows:

A. Upon thirty (30) days written notice of termination for cause (such as fraudulent use of an Identification Card) by the HMO. The HMO will not terminate a Member's coverage because of health status, need for Medically Necessary Covered Services, or having exercised rights under the Complaint and Grievance Appeal Process;

B. The HMO may void this Agreement within three (3) years of the Effective Date of Coverage if it is found that this Agreement was obtained or maintained by supplying materially incorrect or misleading enrollment eligibility information, except in the case of fraudulent statements or omissions, or if you commit a material misrepresentation or fraud in applying for or obtaining coverage or benefits from the HMO, for which there is no time limit for voidance, subject to rights under the Complaint and Grievance Appeal Process. The Subscriber will forfeit any charges paid to the extent of the liability incurred by the HMO;

C. For the misuse of the Member ID Card;

D. For non-payment of premium subject to applicable grace period shown herein (See "Grace Period" provision under Section GP – General Provisions).

E. The HMO may, at its option, amend this Agreement at least annually.

F. Except as provided under Section GP – General Provisions, the HMO shall not be liable for any services provided to any Member beyond the period for which the required payment shall have been received by the HMO.

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

OBLIGATIONS ON TERMINATION OF THE AGREEMENT

A. **Non-Payment of Premium**
Coverage shall remain in effect during the applicable grace period (See "Grace Period" provision under Section GP – General Provisions).

B. **Inpatient Provision**
If the Member is receiving Inpatient Care in a Hospital or Skilled Nursing Facility on the day this coverage is terminated by the HMO, except for termination due to fraud or intentional misrepresentation of a material fact , the benefits of this Agreement shall be provided until the earliest of:

1. the expiration of such benefits according to Section SC - Schedule Of Cost Sharing & Limitations; or
2. determination of the Primary Care Physician and the HMO that Inpatient Care is no longer Medically Necessary; or
3. the Member's discharge from the facility.

NOTE: The HMO will not terminate your coverage because of your health status, your need for Medically Necessary Covered Services or your having exercised rights under the Complaint And Grievance Appeal Process. When a Subscriber's coverage terminates for any reason, coverage of the Subscriber's covered family members will also terminate.

SECTION CS – DESCRIPTION OF COVERED SERVICES

Subject to the Exclusions, conditions and limitations specified in this Agreement, a Member shall be entitled to receive the Covered Services listed below. A Member may be required to make a Copayment or there may be limits on services and other cost sharing requirements as specified in Section SC - Schedule Of Cost Sharing & Limitations of this Agreement.

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

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

Some Covered Services must be Preapproved before you receive the services. The Primary Care Physician or Participating Specialist must seek the HMO's approval and confirm that coverage is provided for certain services. Preapproval of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Preapproval helps determine whether a different treatment may be available that is equally effective yet less traumatic. Preapproval also helps determine the most appropriate setting for certain services. If a Primary Care Physician or Participating Specialist provides Covered Services or Referrals without obtaining such Preapproval, you will not be responsible for payment. More information on Preapproval is found in Section MC – Using the HMO System of this Agreement. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

PRIMARY AND PREVENTIVE CARE

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

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. The Referral is valid for ninety (90) days from date of issue so long as you are still enrolled in this plan. Self-Referrals are excluded, except for Emergency care. Additional Covered Services recommended by the Referred Specialist will require another Referral from your Primary Care Physician. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

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

"Primary Care" services generally describe health care services performed to treat an illness or

injury.

The HMO periodically reviews the Primary and Preventive Care Covered Services based on recommendations from organizations such as:

- The American Academy of Pediatrics;
- The American College of Physicians;
- the U.S. Preventive Services Task Force; and
- The American Cancer Society.

Accordingly, the frequency and eligibility of Covered Services are subject to change. A list of Preventive Care Covered Services can be found in the Preventive Schedule document. A complete listing of recommendations and guidelines can be found at https://www.healthcare.gov/preventive-care-benefits/.

The HMO reserves the right to modify coverage the Preventive Schedule document at any time after written notice of the change has been given to you.

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

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

In addition to Office Visits, a Member may receive medical care at a Retail Clinic. Retail Clinics are staffed by certified family nurse practitioners who are trained to diagnose, treat, and write prescriptions when clinically appropriate. Nurse practitioners are supported by a local Physician who is on-call during clinic hours to provide guidance and direction when necessary. Examples of treatment and services that are provided at a Retail Clinic include, but are not limited to: sore throat; ear, eye, or sinus infection; allergies; minor burns; skin infections or rashes and pregnancy testing.

Adult Preventive Care
Adult Preventive Care includes routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document attached to this Agreement.

Pediatric Preventive Care
Pediatric Preventive Care includes routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document attached to this Agreement.

Well Woman Preventive Care
Well Woman Preventive Care includes coverage for an initial physical examination for pregnant women to confirm pregnancy, screening for gestational diabetes, and other Covered Services, in accordance with the Preventive Schedule document attached to this Agreement.

Covered Services and Supplies include, but are not limited to, the following:

- **Routine Gynecological Exam, Pap Smear**. Female Members are covered for one (1) routine gynecological exam each Benefit Period. This includes a pelvic exam and clinical breast exam; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. Female Members have "direct access" to care by a Participating Obstetrician or Gynecologist. This means there is no Primary Care Physician Referral needed.
- **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. Copayments, if any, do not apply to this benefit.
- **Breastfeeding comprehensive support and counseling** from trained Providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and Participating Obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member when provided by a Participating Provider.
- **Contraception**: Food and Drug Administration-approved contraceptive methods, including contraceptive devices, injectable contraceptives, IUDs and implants; sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost share to the Member when provided by a Participating Provider. Contraception drugs and devices are covered under the Prescription Drug benefit issued with the plan.

If a female Member's Physician determines that they require more than one well-women visit annually to obtain all recommended preventive services (based on the women's health status, health needs and other risk factors), the additional visit(s) will be provided without cost-sharing.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)
Coverage is provided for Bone Mineral Density Testing (BMDT), in accordance with the Preventive Schedule document. The method used needs to be one that is approved by the U.S. Food and Drug Administration. 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.

Immunizations
Coverage will be provided for:
- pediatric immunizations;
- adult immunizations (except those required for employment or travel);
- the agents used for the immunizations,

All immunizations, including the agents used for them, must 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 schedules may be found in the Preventive Schedule document.

Nutrition Counseling for Weight Management
Benefits are provided for nutrition counseling visits/sessions for the purpose of weight

management when performed by your network Physician specialist or a Registered Dietitian (RD).

This benefit is in addition to any other nutrition counseling Covered Services described in this Agreement. A Referral from your Primary Care Physician is not required to obtain services for Nutrition Counseling for Weight Management.

Smoking Cessation
Smoking cessation includes clinical preventive services rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) as described under the Preventive Services provision of the Patient Protection and Affordable Care Act.

INPATIENT COVERED SERVICES

Services for Inpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by the HMO. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. Your Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency care. Additional Covered Services recommended by the Referred Specialist will require another electronic Referral from your Primary Care Physician. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Hospital Services
A. Ancillary Services
Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including, but not limited to, the following:
1. Meals, including special meals or dietary services as required by your condition;
2. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
3. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
4. Oxygen and oxygen therapy;
5. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
6. Therapy Services, Habilitative Services, and Rehabilitative Services when administered by a person who is appropriately licensed and authorized to perform such services;
7. All Prescription Drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals. (The HMO reserves the right to apply quantity level limits as conveyed by the FDA or the HMO's Pharmacy and Therapeutics Committee for certain Prescription Drugs);

8. Use of special care units, including, but not limited to, intensive or coronary care and related services;
9. Pre-admission testing.

B. Room and Board
Benefits are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:
1. An average semi-private room, as designated by the Hospital; or a private room, when designated by the HMO as semi-private for the purposes of this plan in Hospitals having primarily private rooms;
2. A private room, when Medically Necessary;
3. A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
4. A bed in a general ward; and
5. Nursery facilities.

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

A. Concurrent Care
Services rendered to you while an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Referred Specialist who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of you, standby services, routine preoperative physical exams or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by the Participating Facility Provider's rules and regulations.

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

Skilled Nursing Care Facility
Benefits are provided for a Participating Skilled Nursing Care Facility, when Medically Necessary as determined by the HMO.

You must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility.

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

help with your discharge and if necessary, arrange for other medical services.

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

INPATIENT / OUTPATIENT COVERED SERVICES

Services for Inpatient / Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by the HMO. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. Your Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency care. Additional Covered Services recommended by the Referred Specialist will require another Referral from your Primary Care Physician. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

Autologous Blood Drawing/Blood/Storage/Transfusion

Covered Services include the administration of blood and blood processing from donors. In addition, autologous blood drawing, storage or transfusion - i.e., an individual having his own blood drawn and stored for personal use, such as self-donation in advance of planned Surgery are Covered Services.

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

Hospice Services

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

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

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

Maternity and Obstetrical Care Services

A. Maternity/Obstetrical Care
Services rendered in the care and management of your pregnancy are Covered Services under this plan. Your Participating Obstetrician or Gynecologist will notify the HMO of your maternity care within one (1) month of the first prenatal visit to that Provider. Covered Services include: (1) facility services provided by a Participating Facility Provider that is a Hospital or Birth Center; and (2) professional services performed by a Participating Obstetrician or Gynecologist that is a Physician or a Certified Nurse Midwife. Benefits are also payable for certain services provided by a Participating Obstetrician or Gynecologist for elective home births.

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

In the event of early post-partum discharge from an Inpatient Stay, benefits are provided for Home Health Care as described in the Home Health Care item under the Outpatient Covered Services listed later in the section.

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

C. Newborn Care
The newborn child of a Member 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 Section EL – Eligibility, Change and Termination Rules Under the Plan of this Agreement.

D. Artificial Insemination
Facility services provided by a Participating Facility Provider and services performed by a Participating Specialist for the promotion of fertilization of a female recipient's own ova (eggs):
1. By the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying:
   a. Simple sperm preparation;
   b. Sperm washing; and/or
   c. Thawing**.**

Mental Health Care and Serious Mental Illness Health Care

Benefits for the treatment of Mental Health Care and Serious Mental Illness Health Care are based on the services provided and reported by the Participating Behavioral Health/Alcohol Or

Drug Abuse And Dependency Provider.

When a Participating Professional Provider other than a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider, renders Medical Care to the Member other than Mental Health Care or Serious Mental Illness Health Care, coverage for such Medical Care will be based on the medical benefits available as shown in the Schedule of Covered Services included with this Agreement.

A Referral from your Primary Care Physician is not required to obtain Inpatient or Outpatient Mental Health Care or Outpatient Serious Mental Illness Health Care. You may contact your Primary Care Physician or call: 1-800-688-1911 (TTY: 711).

Inpatient Mental Health Care and Serious Mental Illness Health Care

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

a. For the treatment of a mental illness, including a Serious Mental Illness;
b. When provided by a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

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

Outpatient Mental Health Care and Serious Mental Illness Health Care

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

a. For the treatment of a Mental Illness, including a Serious Mental Illness;
b. When provided by a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

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

The criteria for Medical Necessity determinations made by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider with respect to Mental Health and Serious Mental Illness Health Care benefits will be made available to the Member upon request.

Routine Patient Costs Associated With Qualifying Clinical Trials

Benefits are provided for Routine Patient Costs Associated With Participation in a Qualifying Clinical Trial (see Section DE - Definitions). To ensure coverage and appropriate claims processing, the HMO must be notified in advance of the Member's participation in a Qualifying Clinical Trial.

Benefits are payable if the Qualifying Clinical Trial is conducted by a Participating Professional

Provider, and conducted in a Participating Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Participating Professional Provider, and in a Participating Facility Provider, then the HMO will consider the services by a Non-Participating Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see Section DE - Definitions) by the HMO.

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

A. Congenital Cleft Palate
   The orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft Surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and

B. Mastectomy Care
   Coverage for the following when performed subsequent to mastectomy:
   1. All stages of reconstruction of the breast on which the mastectomy has been performed;
   2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
   3. Prostheses and physical complications all stages of mastectomy, including lymphedemas; and
   4. Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy.

Coverage is also provided for:
   1. The surgical procedure performed in connection with the initial and subsequent, insertion or removal of Prosthetic Devices to replace the removed breast or portions thereof; and
   2. The treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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

D. Hospital Admission for Dental Procedures or Dental Surgery
   Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when you have an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure your health. Dental procedures or Surgery performed during such a confinement will only be covered for the services described in “Oral Surgery” and “Assistant at Surgery” provisions.

E. Oral Surgery
   Oral Surgery is subject to special conditions as described below:
   1. Orthognathic surgery – Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
      a. The initial treatment of Accidental Injury or trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.
      b. In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
      c. In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard

deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic Surgery will decrease airway resistance, improve breathing, or restore swallowing

2. Other oral Surgery - defined as Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered Service will only be provided for:
   a. Surgical removal of impacted teeth which are partially or completely covered by bone;
   b. Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
   c. Surgical removal of teeth prior to cardiac Surgery, Radiation Therapy or organ transplantation.

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

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

   General Anesthesia, along with hospitalization and all related medical expenses normally Incurred as a result of the administration of general Anesthesia, when rendered in conjunction with dental care provided to Members age seven (7) or under and for developmentally disabled Members when determined by the HMO to be Medically Necessary and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

H. Second Surgical Opinion (Voluntary)
   Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. "Elective Surgery" is that Surgery which is not of an Emergency or life threatening nature.

   Such Covered Services must be performed and billed by a Participating Specialist other than the one who initially recommended performing the Surgery.

Transplant Services

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

The determination of Medical Necessity for transplants will take into account the proposed procedure's suitability for the potential recipient and the availability of an appropriate facility for performing the procedure.

Eligibility for Covered Services related to human organ, bone and tissue transplant are as follows.

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

A. When both the recipient and the donor are Members, the payment of their respective medical expenses shall be covered by their respective benefit programs.
B. When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under the Agreement. However, donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.
C. When only the recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under the Agreement.
D. When only the donor is a Member, the donor is entitled to the benefits of the Agreement for all related donor expenses, subject to following additional limitations:
    1. The benefits are limited to only those benefits not provided or available to the donor from any other source of funding or coverage in accordance with the terms of the Agreement; and
    2. No benefits will be provided to the non-Member transplant recipient.

E. If any organ or tissue is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered. Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program. Covered Services of a donor include:
    - Removal of the organ;
    - Preparatory pathologic and medical examinations; and
    - Post-surgical care.

Treatment of Alcohol Or Drug Abuse And Dependency

Benefits for the treatment of Alcohol Or Drug Abuse And Dependency are based on the services provided and reported by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

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

1. Inpatient Alcohol Or Drug Abuse And Dependency Treatment

    Benefits are provided for Covered Services during an Inpatient Alcohol Or Drug Abuse And Dependency Treatment admission:

    a. For the diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency, including Detoxification; and

b. At a Participating Facility Provider that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

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

Inpatient benefits include:

a. Lodging and dietary services;
b. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
c. Services provided by a staff Physician, Psychologist, registered or licensed practical nurse, and/or certified addictions counselor;
d. Rehabilitation therapy and counseling;
e. Family counseling and intervention; and
f. Prescription Drugs, medicines, supplies and use of equipment provided by the Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

2. Outpatient Alcohol Or Drug Abuse And Dependency Treatment

Benefits are provided for Covered Services during an Outpatient Alcohol Or Drug Abuse And Dependency Treatment visit/session:

a. For the diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency , including Detoxification by the appropriately licensed Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider; and
b. At a Participating Facility Provider that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

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

Outpatient Alcohol Or Drug Abuse And Dependency Treatment Covered Services include:

a. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
b. Services provided by the Behavioral Health/Alcohol Or Drug Abuse And Dependency Providers on staff;
c. Rehabilitation therapy and counseling;
d. Family counseling and intervention; and
e. Medication management and use of equipment provided by the Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

The criteria for Medical Necessity determinations made by the Participating Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider with respect to Alcohol Or Drug Abuse And Dependency disorder benefits will be made available to the Member upon request.

OUTPATIENT COVERED SERVICES

Services for Outpatient Care are Covered Services when:

- Medically Necessary;
- Provided or Referred by your Primary Care Physician; and
- Preapproved by the HMO. To access a complete list of services that require Preapproval, log onto the HMO website at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

Services resulting from Referrals to Non-Participating Providers will be covered when the Referral is issued by your Primary Care Physician and Preapproved by the HMO. The Referral is valid for ninety (90) days from date of issue. Self-Referrals are excluded, except for Emergency care. Additional Covered Services recommended by the Participating Specialist will require another Referral from your Primary Care Physician. If you receive any bills from the Provider, you need to contact Customer Service at the telephone number on the back of your ID Card. When you notify the HMO about these bills, the HMO will resolve the balance billing.

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

A. the vehicle is licensed as an ambulance where required by applicable law;
B. the ambulance transport is appropriate for the patient's clinical condition;
C. the use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would be contraindicated (i.e. would endanger the patient's medical condition); and,
D. the ambulance transport satisfies the destination and other requirements stated below in either Section 1. For Emergency Ambulance transport or Section 2. For Non-Emergency Ambulance transport.

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

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

2. For Non-Emergency Ambulance transport:
   All non-emergency ambulance transports must be Preapproved by the HMO to determine Medical Necessity which includes specific origin and destination requirements specified in the HMO's policies.

   Non-emergency air or ground transport may be covered to return the Member to a

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

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

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

A. The Member requires intensive Therapy Services, such as Physical, Occupational and/or Speech Therapy five (5) days per week;
B. The Member has the ability to communicate verbally or non-verbally, the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;
C. The Member is willing to participate in a Day Rehabilitation Program; and
D. The Member's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

Dental Services as a Result of Accidental Injury
Covered Services are only provided for:

A. The initial treatment of Accidental Injury or trauma (i.e. fractured facial bones and fractured jaws) in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, consisting of the first caps, crowns, bridges and dentures (but not dental implants), required for the initial treatment for the Accidental Injury or trauma.

B. The preparation of the jaws and gums required for initial replacement of Sound Natural Teeth.

Diabetic Education Program
Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when Prescribed by a Participating Professional Provider legally authorized to Prescribe such items under law. A Referral from your Primary Care Physician is not required to obtain services for the Diabetic Education Program benefits.

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

A. Upon the initial diagnosis of diabetes;
B. A significant change in the patient's symptoms or condition; or
C. The introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Outpatient diabetic education services are Covered Services when provided by a Participating Provider. The Diabetic Education Program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the HMO. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

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

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

Diabetic Equipment and Supplies

Benefits shall be provided for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider, subject to any Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits. Certain Diabetic Equipment and Supplies, including insulin and oral agents, must be purchased at a pharmacy, subject to the cost-sharing arrangements applicable to the Prescription Drug benefit. Certain diabetic equipment and supplies are not available at a pharmacy. In these instances, the diabetic equipment and supplies will be provided under the Durable Medical Equipment benefit subject to the cost-sharing arrangements applicable to Durable Medical Equipment.

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

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

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

A. Routine Diagnostic Services, such as routine radiology (consisting of x-rays, ultrasound and nuclear medicine), routine medical procedures (consisting of Electrocardiogram (ECG), Electroencephalogram (EEG), and other diagnostic medical procedures approved by the HMO) and allergy testing (consisting of percutaneous, intracutaneous and patch tests);
B. Non-Routine Diagnostic Services, such as Nuclear Cardiology Imaging, operative and diagnostic endoscopies, Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRI/MRA), Positron Emission Tomography (PET Scan), Sleep Studies, and Computed Tomography (CT Scan); and
C. Genetic testing and counseling, including those services provided to a Member at risk for a specific disease due to family history or because of exposure to environmental factors that are known to cause physical or mental disorders. When clinical usefulness of specific genetic tests has been established by the HMO, these services are covered for the purpose of diagnosis, screening, predicting the course of a disease, judging the response to a therapy, examining risk for a disease, or reproductive decision-making.

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

A. It is used in the patient's home; and
B. It is obtained through a Participating Durable Medical Equipment Provider.

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

A. A change in your condition requires a change in the DME the HMO will provide repair or replacement of the DME.
B. The DME is broken due to significant damage, defect, or wear, the HMO will provide repair or replacement only if the DME's warranty has expired and it has exceeded its reasonable useful life as determined by the HMO.

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

1. The HMO's responsibility in the case of rented equipment; and,
2. Your responsibility in the case of purchased equipment.

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

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

Habilitative Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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.

Home Health Care does not include special or Private Duty Nursing care.

With respect to Item E above, Home Health Care services will be provided within forty-eight (48) hours if discharge occurs earlier than forty-eight (48) hours of a vaginal delivery or ninety-six (96) hours of a cesarean delivery. No Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include Occupational Therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the HMO.

Home Health Care benefits will be provided only when Prescribed by in a written Plan of Treatment and approved by the HMO.

There is no requirement that you be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.

With the exception of Home Health Care provided to you immediately following an Inpatient release for maternity care, you must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

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

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

   Preapproval is required for those Specialty Drugs noted in the Preapproval list, which is

available online at www.ibxpress.com/preapproval, or by calling Customer Service at the phone number listed on your ID Card. The purchase of any Specialty Drug is subject to cost sharing as shown on Section SC - Schedule of Cost Sharing & Limitations.

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

C. **Self-Administered Prescription Drugs** – generally are not covered except as provided under Section RX – Prescription Drug. For more information on Self-Administered Prescription Drugs, please refer to Section EX-Exclusions.

Laboratory and Pathology Tests
Benefits are provided for Medically Necessary laboratory and pathology services. You are required to have these services performed by your Primary Care Physician's Designated Provider.

Medical Care
Medical Care rendered by a Participating Professional Provider, including a Physician or Surgeon, who provides services to the Member while an Outpatient in a Participating Facility Provider for services related to Surgery or other ambulatory patient services.

Medical Foods and Nutritional Formulas
Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of inherited errors of metabolism (IEMs) such as 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:

the Nutritional Formula is taken orally or through a tube by an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Participating Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this plan.

An estimated basal caloric requirement for Medical Foods and Nutritional Formula is not required for those with IEMs, or for when administered through a tube.

Orthotics
Benefits are provided for:
A. The initial purchase and fitting (per medical episode) of orthotic devices, except foot orthotics unless the Member requires foot orthotics as a result of diabetes.
B. The replacement of covered orthotics for Dependent children when required due to natural growth.

Prosthetic Devices
Benefits will be provided for Prosthetic Devices required as a result of illness or injury. Benefits include but are not limited to:

A. The purchase and fitting, and the necessary adjustments and repairs, of Prosthetic Devices and supplies (except dental prostheses);
B. Supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;

C. With respect to visual Prosthetics when Medically Necessary and Prescribed for one of the following conditions:
    1. Initial contact lenses Prescribed for the treatment of infantile glaucoma;
    2. Initial pinhole glasses Prescribed for use after Surgery for detached retina;
    3. Initial corneal or scleral lenses Prescribed in connection with the treatment of keratoconus or to reduce a corneal irregularity (other than astigmatism);
    4. Initial scleral lenses Prescribed to retain moisture in cases where normal tearing is not present or adequate; and
    5. An initial pair of basic eyeglasses when Prescribed to perform the function of a human lens lost (aphakia) as a result of:
        a. Accidental Injury;
        b. trauma; or
        c. ocular Surgery

The "Repair and Replacement" paragraphs set forth below do not apply to this item C.

Benefits are provided for the replacement of a previously approved Prosthetic Device with an equivalent Prosthetic Device when:

A. There is a significant change in the Member's condition that requires a replacement;
B. The Prosthetic Device breaks because it is defective;
C. The Prosthetic Device breaks because it has exceeded its life duration as determined by the manufacturer; or
D. The Prosthetic Device needs to be replaced for a Dependent child due to the normal growth process when Medically Necessary.

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

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

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

Rehabilitative Services
Benefits are provided for the following forms of therapy:

A. **Occupational Therapy**
    Coverage will also include services rendered by a registered, licensed occupational therapist. You are required to have these services performed by your Primary Care

Physician's Designated Provider.

B. **Physical Therapy**
Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part. You are required to have these services performed by your Primary Care Physician's Designated Provider.

C. **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 speech therapist.

Specialist Office Visit
Benefits will be provided for Specialist Services Medical Care provided in the office by a Participating Specialist. For the purpose of this benefit, "in the office" includes Medical Care visits to the Provider's office, Medical Care visits by the Provider to your residence, or Medical Care consultations by the Provider on an Outpatient basis.

Spinal Manipulation Services
Benefits are provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Telemedicine Services
Benefits are provided for telemedicine services, provided by MDLIVE®, a national network of board certified physicians that provide consultations 24 hours a day, 7 days a week, 365 days a year. MDLIVE® physicians provide standard medical assessments, treatments, care and services to patients via the telephone or secure video when your Primary Care Physician is unavailable or inaccessible. MDLIVE® does not replace an existing primary care physician relationship but enhances it with an efficient, cost-effective alternative for non-emergency medical problems. The applicable cost-sharing requirements are specified in the ***Schedule of Covered Services***. The Member will pay the applicable cost-sharing via credit or debit card prior to the consultation.

Therapy Services
Benefits are provided for the following forms of therapy:

A. **Cardiac Rehabilitation Therapy**
Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

B. **Chemotherapy**
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. Such agents are eligible for coverage when they are injected or infused into the body by a professional provider. The cost of these drugs is covered, provided the drugs are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents and administered as described in this paragraph.

Note: If this Program does not provide coverage for prescription drugs, oral antineoplastic

agents are covered as provided under the benefits described above.

C. **Dialysis**
Benefits are provided for Dialysis treatment when provided in the outpatient facility of a Hospital, a free-standing renal Dialysis facility or in the home. In the case of home Dialysis, Covered Services will include equipment, training, and medical supplies. Private Duty Nursing is not covered as a portion of Dialysis. The decision to provide Covered Services for the purchase or rental of necessary equipment for home Dialysis will be made by the HMO. The Covered Services performed in a Participating Facility Provider or by a Participating Professional Provider for Dialysis are available without a Referral.

D. **Infusion Therapy**
The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a healthcare Provider. Infusion Therapy includes all professional services, supplies, and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Member. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the HMO.

E. **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.

F. **Radiation Therapy**
Benefits are provided for 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.

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

Urgent Care Center
Benefits are provided for Urgent Care Centers, when Medically Necessary as determined by the HMO. Urgent Care Centers are designed to offer immediate evaluation and treatment for acute health conditions that require medical attention in a non-Emergency situation that cannot wait to be addressed by your Primary Care Physician or Retail Clinic. Cost-sharing requirements are specified in Section SC - Schedule of Cost Sharing & Limitations.

SECTION RX – PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits shall be available for Covered Drugs or Supplies dispensed pursuant to a Prescription Drug Order or Refill for use when you are not Inpatient in a Hospital. Benefits for Covered Drugs Or Supplies are subject to cost sharing as shown on Section SC - Schedule Of Cost Sharing & Limitations.

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

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

A description of benefits for your Covered Drugs or Supplies is described below:

- **Drugs From a Participating Pharmacy** - Covered Drugs or Supplies will be furnished by a Participating Pharmacy subject to the Prescription Drug cost share for each Prescription Drug Order or Refill. Cost sharing, Limitations, or maximums are listed in Section SC - Schedule Of Cost Sharing & Limitations.

- **Drugs From a Non-Participating Pharmacy** – Covered Drugs or Supplies furnished by a Non-Participating Pharmacy when you submit acceptable proof of payment with a direct reimbursement form. Your cost share amount for Prescription Drugs purchased from a Non-Participating Pharmacy is listed in Section SC - Schedule Of Cost Sharing & Limitations. However, for Emergency or Urgent Care, the Member will pay the same Prescription Drug cost share level as for a Participating Pharmacy. The Member must submit to the HMO acceptable proof of payment with a direct reimbursement form.

  All claims for payment must be received by the HMO or an agent of the HMO within ninety (90) days of the date of purchase. Direct reimbursement forms may be obtained by contacting Customer Service.

- **Participating Mail Service Pharmacy** - Covered Maintenance Drugs or Supplies will be furnished by a Participating Mail Service Pharmacy subject to the Prescription Drug cost share for each Prescription Drug Order or Refill.

- **Drugs from Retail Participating Pharmacy Same Cost Share as Participating Mail Service Pharmacy** - Benefits shall also be provided for covered Prescription Drugs Prescribed by a Physician for Covered Maintenance Prescription Drugs or Supplies and dispensed by an Act 207 retail Participating Pharmacy. The cost sharing indicated in Section SC - Schedule Of Cost Sharing & Limitations for Participating Mail Order Pharmacies will apply. Benefits are available for up to a 90-day supply. To verify that a retail Pharmacy is a participating Act 207 Pharmacy, access www.ibx.com.

- **Vitamins** that require a Prescription Drug Order or Refill.

- **Prescribing Physician** - Covered Drugs or Supplies, and Maintenance Prescription Drugs Prescribed by your Primary Care Physician or Referred Specialist, and furnished

by a Participating Pharmacy. Generically equivalent pharmaceuticals will be dispensed whenever applicable. Prescription Drugs contained in the Drug Formulary will be Prescribed and dispensed whenever appropriate, pursuant to the professional judgment of the Primary Care Physician, Referred Specialist and/or the Pharmacist. Covered Drugs or Supplies not listed in the Drug Formulary shall be subject to the Non-Preferred Drug Copay. Members will be given a copy of the Formulary and the coverage may exclude, or require, the Member to pay higher cost share for certain Prescription Drugs. To obtain a copy of the Formulary, the Member should call Customer Service at the phone number shown on the back of the ID Card.

- **Self-Administered Medication** – Benefits are provided for Self-Administered Covered Drugs Or Supplies.

- **Insulin**, only by Prescription Drug Order or Refill. Coverage includes oral agents, insulin, disposable insulin needles and syringes, diabetic blood testing strips, lancets and glucometers. There is no Prescription Drug cost share requirement for lancets and glucometers obtained through a Participating Pharmacy or a Participating Mail Service Pharmacy.

- **Dermatological Drugs** - Compounded dermatological preparations containing at least one Federal Legend or State Restricted Drug.

- **Specialty Drugs** - The HMO will provide benefits for covered Specialty Drugs through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program or through the HMO retail pharmacy network for the appropriate cost sharing for Participating Pharmacies indicated in the "Prescription Drugs" subsection of Section SC – Schedule of Cost Sharing & Limitations. Benefits are available for up to a thirty (30) day supply. No benefits shall be provided for covered Specialty Drugs obtained from a Specialty Pharmacy Program other than the PBM's Specialty Pharmacy Program No benefits shall be provided for Specialty drugs obtained through a Non-Participating retail pharmacy.

- Prescription Drug benefits are subject to dispensing level limits as conveyed by the Food and Drug Administration ("FDA") or the HMO's Pharmacy and Therapeutics Committee.

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

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

- **Contraceptive Drugs and Devices** – Coverage includes benefits for Contraceptive Drugs and Devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordability Act for generic products approved by the Federal Food and Drug Administration and for certain brand products (when a generic alternative or equivalent to the brand product does not exist) approved by the Federal Food and Drug Administration are covered at no cost-share to the Member when obtained from an

Participating Pharmacy or Participating Mail Service Pharmacy. Coverage includes oral and injectable contraceptives, diaphragms, cervical caps, rings, transdermal patches, emergency contraceptives and certain over-the-counter contraceptive methods. The noted standard cost-sharing in the "Prescription Drugs" section of the Section SC - Schedule of Cost Sharing & Limitations applies for all other brand products.

SECTION VS – PEDIATRIC VISION BENEFITS

We cover the Outpatient Vision benefits described in this provision for Members under age nineteen (19). All Vision Care benefits under this section end at the end of the month in which the child turns age 19.

A. **Eye examinations** - Routine eye examination and refraction from a Participating Provider subject to the limits shown in Section SC - Schedule of Cost Sharing & Limitations. A list of Participating Providers is available through Customer Service.

B. **Frames and Prescription Lenses** - Vision frames and prescription lenses as shown below and in Section SC - Schedule of Cost Sharing & Limitations.

1. **Participating Provider**: When provided by a Participating Provider, the Member is entitled to the following benefits for vision frames and prescription lenses subject to the limits shown in Section SC - Schedule of Cost Sharing & Limitations when provided by a Participating Provider, and the Member selects the vision frames and prescription lenses from the Pediatric Frame Selection:

   (a) One (1)pair of frames; and

   (b) One (1) set of spectacle lenses that may be plastic or glass lenses, single, bifocal, or trifocal lenses, lenticular lenses, polycarbonate lenses for Dependent children and monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters and/or oversized lenses.

   Benefits are provided for prescription contact lenses in lieu of eyeglasses.

   Frames and prescription lenses covered by this Agreement are limited to the Pediatric Frame Selection of covered frames and prescription lenses. The Participating Provider will show the Member the selection of frames and prescription lenses covered by this Agreement. If the Member selects a frame or prescription lenses that are not included in the Pediatric Frame Selection covered under this Agreement, the Member is responsible for the difference in cost between the Participating Provider reimbursement amount for covered frames and prescription lenses from the Pediatric Frame Selection and the retail price of the frame and prescription lenses selected. Any amount paid to the Participating Provider for the difference in cost of a non-Pediatric Frame Selection frame or prescription lenses will not apply to any applicable Out-Of-Pocket Maximum.

2. **Non-Participating Provider:** When provided by a Non-Participating Provider, no benefits shall be provided for frames and prescription lenses.

SECTION DN – PEDIATRIC DENTAL BENEFITS

A Member under nineteen (19) years of age is entitled to the Dental Covered Services shown in Section SC – Schedule of Cost Sharing & Limitations when provided by a Participating Dentist. To find a Participating Dentist, the Member can visit the HMO's website or call Customer Service at the telephone number on the back of their ID Card. Also, if agreed by the Provider, Participating Dentists limit their charges for all services delivered to Members, even if the service is not covered for any reason and a benefit is not paid under this Agreement. Services provided by a Non-Preferred Dentist are not covered under the Dental Care benefit. Dental Covered Services are subject to the provisions listed below and to the cost sharing listed in Section SC – Schedule of Cost Sharing & Limitations.

SECTION EX - EXCLUSIONS

The following are excluded from your coverage:

1. Services, supplies or charges which are:
   A. Not provided by or Referred by the Member's Primary Care Physician except in an Emergency; or as specified elsewhere in this Agreement;
   B. Not Medically Necessary, as determined by the Primary Care Physician or Referred Specialist or the HMO, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under this Subscriber Agreement; or
   C. Provided by family members, relatives and friends.

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

3. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;

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

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

6. Services, supplies or charges paid or payable by Medicare when Medicare is primary. For purposes of this Subscriber Agreement, a service, supply or charge is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premiums for, maintains, claims or receives Medicare benefits.

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

8. For Members age nineteen (19) and older, dental services and devices related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this Subscriber Agreement. Services not covered include, but are not limited to: apicoectomy (dental root resection); prophylaxis of any kind; root canal treatments; soft tissue impactions; alveolectomy; bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise described in this Subscriber Agreement;
   A. For dental implants for any reason;
   B. For dentures, unless for the initial treatment of an Accidental Injury or trauma;

C. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
D. For oral devices used for temporomandibular joint syndrome or dysfunction;
E. For injury as a result of chewing or biting (neither is considered an Accidental Injury);

9. Charges for broken appointments, services for which the cost is later recovered through legal action, compromise, or claim settlement, and charges for additional treatment necessitated by lack of patient cooperation or failure to follow a Prescribed Plan of Treatment;

10. Services or supplies which are Experimental/Investigative in nature, except Routine Patient Costs Associated With Qualifying Clinical Trials that meet the definition of a Qualifying Clinical Trial under this Agreement, and which have been Preapproved by the HMO.

    Routine patient costs do not include any of the following:
    A. the investigational item, device, or service, itself;
    B. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
    C. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

11. Routine physical examinations for non-preventive purposes, such as pre-marital examinations physicals for college, camp or travel; and examinations for insurance, licensing and employment;

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

13. Cosmetic Surgery, including cosmetic dental Surgery. Cosmetic Surgery is defined as any Surgery done primarily to alter or improve the appearance of any portion of the body, and from which no significant improvement in physiological function could be reasonably expected.

    This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to, the ears, lips, chin, jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

    This exclusion does not include those services performed when the patient is a Member of the HMO and performed in order to restore bodily function or correct deformity resulting from a disease, recent trauma, or previous therapeutic process.

    This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities for children;

14. Any Therapy Service provided for: ongoing outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond the plan's day limits, if any, shown on Section SC - Schedule Of Cost Sharing & Limitations; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;

15. Vision care including, but not limited to:
    A. All surgical procedures performed solely to eliminate the need for or reduce the Prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty;
    B. For Members age nineteen (19) and older, any eyeglasses, lenses or contact lenses and the vision examination for Prescribing or fitting eyeglasses or contact lenses except as otherwise described in this Subscriber Agreement; and
    C. Lenses which do not require a Prescription;
    D. Any lens customization such as, but not limited to tinting, oversize or progressive lenses; antireflective coatings, U-V lenses or coatings, scratch resistant coatings, mirror coatings, or polarization;
    E. Deluxe frames; or
    F. Eyeglass accessories such as cases, cleaning solution and equipment.

16. Any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Developmental Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or intellectual disability; or treatment or care to effect environmental or social change;

17. Immunizations required for employment purposes or travel. This exclusion does not apply to travel immunizations required by ACIP.

18. Custodial and Domiciliary Care, residential care, protective and supportive care, including educational services, rest cures and convalescent care;

19. Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary. This exclusion does not apply to the HMO's weight reduction program or nutrition counseling visits/sessions as described in the Nutrition Counseling for Weight Management provision in this Agreement;

20. For appetite suppressants;

21. For oral non-elemental nutritional supplements (e.g. Boost, Ensure, PediaSure), casein hydrolyzed formulas (e.g. Nutramigen, Alimentum, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, soy-based products. 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;

22. For elemental semi-solid foods (e.g. Neocate Nutra);

23. For products that replace fluids and electrolytes (e.g. Electrolyte Gastro, Pedialyte)

24. For additives (e.g. Duocal, fiber, or vitamins) and food thickeners (e.g. Thick-It, Resource ThickenUp);

25. For supplies associated with the oral administration of formula (e.g. bottles, nipples).

26. Customized wheelchairs;

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

28. For routine foot care as defined in the HMO's medical policy, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

29. Marriage or religious counseling;

30. For the Maintenance of chronic conditions, illness or injury;

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

32. Ambulance service, unless Medically Necessary and as provided in the subsection entitled "Ambulance" specified in Section CS – Description of Covered Services of this Agreement;

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

34. Charges for completion of any insurance form;

35. For Prescription Drugs and medications, except as provided under the Prescription Drug Benefit described in this Agreement;

36. For Contraceptives, except as covered under the Prescription Drug Benefit described in this Agreement;

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

38. For over-the-counter drugs, or any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient Stay;

39. The following outpatient services that are not performed by your Primary Care Physician's Designated Provider, when required under the HMO plan, unless Preapproved by the HMO: (a) Rehabilitation Therapy Services (other than Speech Therapy); (b) diagnostic radiology services for Members age five (5) or older; and (c) laboratory and pathology tests;

40. For Cognitive Rehabilitative Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (For example: stroke, acute brain insult, encephalopathy);

41. Inpatient or Outpatient Care Private Duty Nursing services;

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

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

This exclusion does not apply to Self-Administered Prescription Drugs that are:

- Covered under Section RX – Prescription Drugs;
- 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 benefit or free-standing prescription drug contract issued by the HMO or its affiliates; or
- Required for treatment of an Emergency condition that requires a Self-Administered Prescription Drug.

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

45. Services Incurred prior to the Effective Date of Coverage;

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

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

48. Charges not billed and performed by a Provider;

49. Services performed by a Professional Provider enrolled in an educational or training program when such services are related to the educational or training program and are provided through a hospital or university;

50. For treatment of obesity, including for surgical treatment of obesity. This includes, but is not limited to: (a) weight management programs, (b) dietary aids, supplements, injections and medications (c) weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician (d) group nutrition counseling.

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

51. Charges in excess of benefit maximums;

52. Counseling with patient's relatives except as may be specifically provided in the subsection entitled "Treatment of Alcohol Or Drug Abuse And Dependency" or "Transplant Services" specified in Section CS – Description of Covered Services of this Agreement;

53. For sex therapy or other forms of counseling for treatment of sexual dysfunction;

54. With regard to Durable Medical Equipment (DME), equipment for which any of the following statements are true is not DME and will not be covered. Any item:
    A. That is for comfort or convenience. Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps; telephone alert systems; bed-wetting alarms; and ramps.
    B. That is inappropriate for home use. This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes.
    C. That is a non-reusable supply or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not covered include, but are not limited to: incontinence pads; lamb's wool pads; ace bandages; catheters (non-urinary); face masks (surgical); disposable gloves, sheets and bags; and irrigating kits.
    D. That is not primarily medical in nature. Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to: ear plugs; exercise equipment; ice pack; speech teaching machines; strollers; silverware/utensils; feeding chairs; toileting systems; toilet seats; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.
    E. That has features of a medical nature which are not required by the patient's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.
    F. That duplicates or supplements existing equipment for use when traveling or for an additional residence. For example, a patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would not be eligible for two identical items, or one for each living space.
    G. Which is not customarily billed for by the Provider. Items not covered include, but are not limited to: delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.
    H. That modifies vehicles, dwellings, and other structures. This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability or (ii) any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
    I. 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.
    J. That is for environmental control. Items not covered include, but are not limited to: air cleaners; air conditioners; dehumidifiers; portable room heaters; and ambient heating and cooling equipment.

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

55. For Skilled Nursing Facility benefits:
    A. When confinement is intended solely to assist a Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
    B. For the treatment of Alcohol Or Drug Abuse And Dependency and Mental Illness Health

Care; or

C. After the Member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine Custodial Care.

56. For Hospice Care benefits for the following:
    A. Private Duty Nursing care;
    B. Research studies directed to life lengthening methods of treatment;
    C. Expenses Incurred in regard to the Member's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property); or
    D. Treatment to cure the Member's illness.

57. With regard to Home Health Care services and supplies in connection with home health services for the following:
    A. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
    B. Rental or purchase of Durable Medical Equipment;
    C. Rental or purchase of medical appliances (e.g., braces) and Prosthetic Devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
    D. Prescription Drugs;
    E. Provided by family members, relatives, and friends;
    F. A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
    G. Emergency or non-emergency ambulance services;
    H. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
    I. Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
    J. Visits by any Provider personnel solely for the purpose of assessing a Member's condition and determining whether or not the Member requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

58. For home blood pressure machines, except for Members: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, (c) with end-stage renal disease receiving home Dialysis, or (d) who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates;

59. Any services, supplies or treatments not specifically listed in this Agreement as covered benefits, unless the unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health. The HMO reserves the right to specify Providers of, or means of delivery of Covered Services, supplies or treatments under this plan, and to substitute such Providers or sources where medically appropriate;

60. Hearing or audiometric examinations, and Hearing Aids, including cochlear electromagnetic hearing devices and the fitting thereof. and, routine hearing examinations; Services and supplies related to these items are not covered;

61. Foot orthotic devices except as described in this Subscriber Agreement. This exclusion does not apply to foot orthotic devices used for the treatment of diabetes;

62. Wigs and other items intended to replace hair loss due to male/female pattern baldness; or due to illness or injury including but not limited to injury due to traumatic or surgical scalp avulsion, burns, or Chemotherapy;

63. For assisted fertilization techniques such as, but not limited to, in vitro fertilization; embryo transplant; ovum retrieval, including gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any services required in connection with these procedures;

64. Services for repairs or replacements of Prosthetic Devices or Durable Medical Equipment needed because the item was abused, lost or misplaced;

65. For Alternative Therapies/Complementary Medicine, including but not limited to: acupuncture; music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; rolfing; psychodrama; vitamin or other dietary supplements and therapy; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; and sleep therapy;

66. For services, supplies or charges a Member is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Member;

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

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

69. Charges for Orthoptic/Pleoptic Therapy;

70. The following exclusions apply to your **Prescription Drug benefits**:
    A. Devices of any type, even though such devices may require a Prescription Order. This includes, but is not limited to, therapeutic devices or appliances, hypodermic needles, syringes or similar devices, support garments or other devices, regardless of their intended use, except as specified as a benefit in your Subscriber Agreement. This exclusion does not apply to (a) devices used for the treatment or Maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and (b) devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines; or (c) Contraceptive devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordable Care Act.
    B. Drugs Prescribed and administered in the Physician's office;
    C. Drugs which do not by federal or state law require a Prescription Order (i.e., over-the-counter) or drugs that require a Prescription Order but have an over-the-counter equivalent, except insulin, over-the counter drugs that are Prescribed by a Physician in accordance with applicable law, and drugs specifically designated by the HMO, whether or not Prescribed by a Physician.
    D. Any drugs covered under another provision of the Agreement;
    E. Prescription Drugs covered without charge under federal, state or local programs

including Worker's Compensation and Occupational Disease laws;

F. Medication for a Member confined to a rest home, Skilled Nursing Facility, sanitarium, extended care facility, Hospital or similar entity;
G. Medication furnished by any other medical service for which no charge is made to the Member;
H. Any Covered Drug or Supply administered at the time and place of the Prescription Order;
I. Any charges for the administration of Prescription Legend Drugs or injectable insulin;
J. Prescription Drugs provided by Non-Participating Pharmacies, except as specified in Section RX-Prescription Drug Benefits;
K. Prescription Refills resulting from loss or theft, or any unauthorized Refills;
L. Immunization agents, biological sera, blood or plasma, or allergy serum;
M. Experimental or Investigational Drugs or drugs Prescribed for experimental (non-FDA approved) indications;
N. Drugs used for cosmetic purposes, including but not limited to, anabolic steroids, minoxidil lotion, and Retin A (tretinoin), when used for non-acne related conditions. However, this exclusion does not include drugs Prescribed to treat medically diagnosed congenital defects and birth abnormalities;
O. Pharmacological therapy for weight reduction or diet agents, unless Preapproved by the HMO;
P. Injectable drugs, including injectable drugs used for the primary purpose of treating infertility or injectable drugs for fertilization. This exclusion does not include injectable Contraceptive Drugs;
Q. Prescription Drugs not approved by the HMO or Prescribed drug amounts exceeding the quantity level limits as conveyed by the FDA or the HMO's Pharmacy and Therapeutics Committee;
R. Specialty Drugs that are not purchased through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program. This exclusion does not apply to Insulin;
S. Any charge where the usual and customary charge is less than the Member's cost-sharing amount.

71. The following Exclusions apply to your **Pediatric Dental benefits**:

Only American Dental Association procedure codes are covered. **Except as specifically provided in this Agreement, no coverage will be provided for services, supplies or charges that are:**

A. Incurred prior to the Subscriber's Effective Date of Coverage or after the Termination Date of coverage under the Individual Agreement.
B. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
C. For prescription and non-prescription drugs, vitamins or dietary supplements.
D. Cosmetic in nature as determined by the HMO (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
E. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
F. For congenital mouth malformations or skeletal imbalances (for example but not limited to, treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment). This exclusion shall not apply to newly born children of Subscribers including newly

adoptive children, regardless of age.

G. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Agreement. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
H. For treatment of fractures and dislocations of the jaw.
I. For treatment of malignancies or neoplasms.
J. For services and/or appliances that alter the vertical dimension (for example but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
K. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
L. For periodontal splinting of teeth by any method.
M. For duplicate dentures, Prosthetic Devices or any other duplicative device.
N. For which in the absence of insurance the Member would Incur no charge.
O. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
P. For treatment and appliances for bruxism (night grinding of teeth).
Q. For any claims submitted to the HMO by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
R. For incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).
S. For procedures that are:
   - part of a service but are reported as separate services; or
   - reported in a treatment sequence that is not appropriate; or
   - misreported or that represent a procedure other than the one reported.
T. For specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).
U. Fees for broken appointments.
V. Not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the HMO will apply.
W. Orthodontic treatment is not a Covered Service unless deemed Medically Necessary and a written treatment plan is approved by the HMO.
   Orthodontic services for the following are excluded:
   - Treatments that are primarily for Cosmetic reasons;
   - Treatments for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment)
   - Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under Section SC – Schedule of Cost Sharing & Limitations. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

72. Any Mental Health Care, Serious Mental Illness Health Care, or Alcohol Or Drug Abuse And Dependency treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as Alternative Therapies/Complementary Medicine and obesity control therapy.

73. Non-medical services, such as vocational rehabilitation or employment counseling, for the treatment of Alcohol Or Drug Abuse And Dependency in an acute care Hospital.

SECTION GP – GENERAL PROVISIONS

BENEFIT PROVISIONS

A. In consideration of payments to be paid to the HMO by the Subscriber and, in consideration of the Copayments, if required, to be paid by or on behalf of Members, the HMO agrees to provide access to medical and Hospital Covered Services and other benefits as specified in this Agreement for eligible persons who enroll hereunder, in accordance with the terms, conditions, Limitations, and exclusions of this Agreement.

B. Except as may be provided under Section CS – Description of Covered Services, Inpatient Services, Organ Transplants, no person other than a Member is entitled to receive benefits under this Agreement.

C. Benefits for Covered Services specified in this Agreement will be provided only for Covered Services and supplies that are rendered by a Provider as specified in Section CS – Description of Covered Services of this Agreement.

D. **Erroneous Payment**. If the HMO shall pay for any excluded services or supplies through inadvertence or error, the Member shall reimburse the HMO for such payments.

E. **Illegal Acts**. The HMO shall not be liable for any services to which a contributing cause was the Member's commission of or attempt to commit a felony, or to which a contributing cause was the Member's being engaged in an illegal occupation. If services are rendered, the Member will be held responsible for payment.

F. **Identification Cards**. Identification Cards issued by the HMO to Members pursuant to this Agreement are for identification purposes only. Possession of an HMO Identification Card confers no rights to Covered Services or other benefits under this Agreement.

To be entitled to such Covered Services or benefits the holder of the card must, in fact, be a Member on whose behalf all applicable payments under this Agreement have been paid. Any person receiving Covered Services or benefits to which he or she is not entitled pursuant to the provisions of this Agreement is chargeable therefore at the expense Incurred by the HMO. For purposes of identification and specific coverage information, a Member's Identification Card must be presented when a Covered Service is requested.

G. **Determination of Medical Necessity**. The Covered Services or supplies described in Section CS – Description of Covered Services of this Agreement are covered only when they are Medically Necessary, as determined by a Participating Provider or the HMO. Any services requested by a Member which are not Medically Necessary, except as provided under Section CS – Description of Covered Services of this Agreement, will not be covered.

H. **Assignment**. Except as set forth in this Agreement, the Subscriber is solely responsible for the performance of his or her obligations set forth in this Agreement. The Subscriber cannot assign, delegate, or transfer to any party any rights, duties, or obligations described in this Agreement, any interest in this Agreement, or any claim under this Agreement without the prior express written consent of the HMO.

I. **Relationship of Parties**

1. The relationship between the HMO and its Participating Providers, and between the HMO and other contracting Providers of health services, is an independent contract relationship.

   The HMO Participating Providers are not agents or employees of the HMO, nor is any employee of the HMO an employee or agent of the HMO Participating Providers.
2. The HMO shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any HMO Participating Provider or from any Provider to which the Member has been Referred by the Participating Provider or the HMO.
3. The HMO Participating Providers maintain the Physician-patient relationship with Members and are responsible to Members for the delivery of all medical services.
4. Members are free to choose their Primary Care Physician as described in Section ACC – Access To Primary, Specialist And Hospital Care.

J. **Legal Action.** No legal action may be commenced against the HMO with respect to the Agreement until at least sixty (60) days after the HMO has received a properly completed claim form, Referral or encounter form. No legal action against the HMO with respect to the Agreement may be filed later than three (3) years after the Covered Services or supplies were performed or provided.

   In addition, no legal action regarding a Complaint or Grievance may be commenced against the HMO until the Member has exhausted his or her administrative remedies and appeals as detailed in this Agreement.

CLERICAL ERROR

Clerical error, whether of the Subscriber or the HMO, in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

DISCOUNTS AND WELLNESS/REWARD INCENTIVES PROGRAMS

A. **Discount Arrangements**. Discount arrangements are not insurance. From time to time, the HMO may offer, provide or arrange for discount arrangements or special rates from certain service providers such as, wellness and healthy living providers to Subscribers enrolled in this Agreement. Some of these arrangements may be made available through third parties. The third party service providers are independent contractors and are solely responsible to the Member for the provision of any such goods and/or services. The HMO reserves the right to modify or discontinue such arrangements at any time. There are no benefits payable to the Member nor does the HMO compensate providers for services they may render though discount arrangements.

B. **Wellness/Reward Incentives**. In connection with a wellness or health improvement program, the HMO may provide incentives, including but not limited to, gift certificates, prizes, or any combination thereof. The HMO reserves the right to modify or discontinue such incentives at any time. The award of any such incentive shall not be contingent upon the outcome of a wellness or health improvement activity or upon a Member's health status.

ENTIRE AGREEMENT AND CHANGES

A. The entire Agreement between the HMO and the Subscriber consists of the Application/Change Form(s), this Subscriber Agreement, Riders and amendments to these documents (effective now or in the future), and the appropriate payment.
B. No change in this Agreement will be effective until approved by an authorized officer of the HMO. This approval must be noted on or attached to this Agreement. No agent or representative of the HMO other than an officer of the HMO, may otherwise change this Agreement or waive any of its provisions. All statements made by an individual Member shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense of a claim under this Agreement, unless it is contained in a written Application/Change Form.
C. The HMO may amend this Agreement with respect to any matter, including required payments, by mailing a postage prepaid notice of the amendments to the Subscriber at his address of record with the HMO, at least thirty (30) days before the effective date of the amendment. The Subscriber's concurrence with such amendments shall be established by continuation of payment for coverage hereunder after the effective date of the amendment.
D. If the provisions of the Agreement do not conform to the requirements of any state or federal law or regulation that applies to the Agreement, the Agreement provisions are automatically changed to conform with the HMO's interpretation of the requirements of that law or regulation.

GENDER

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

GRACE PERIOD

A. This Agreement has a grace period of **thirty (30) days**, unless you are an individual enrolled in an Exchange product who receives a tax credit, the grace period is **three (3) months**. 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 Agreement will stay in force, unless prior to the date payment was due, the Subscriber gave timely written notice to the HMO that the Agreement is to be cancelled.

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

IDENTITY PROTECTION SERVICES

From time to time, the HMO may offer, provide or arrange for identity protection services to Subscribers enrolled in this Agreement. These services may be made available through third parties. The third party service providers are independent contractors and are solely responsible to the Subscribers for the provision of any such services. The HMO reserves the right to modify or discontinue such services at any time.

INTERPRETATION OF SUBSCRIBER AGREEMENT

The laws of the Commonwealth of Pennsylvania shall be applied to interpretations of this Subscriber Agreement.

MODIFICATION

By this Agreement, HMO coverage is made available to Subscribers and their Dependents who are eligible under Section EL – Eligibility, Change And Termination Rules Under The Plan of this Agreement. However, this Agreement shall be subject to amendment, modification and termination in accordance with any provision hereof without the consent or concurrence of the Members.

By electing this coverage or accepting benefits provided in this Agreement, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof. Any changes to this Agreement shall be in writing and must be approved and executed by an authorized officer of the HMO. Such changes will be made through an Amendment to the Agreement. The HMO will not be bound by any promise or representation made by or to any other person.

The HMO may unilaterally modify the terms of this Agreement if notice of such modification is given at least thirty (30) days prior to the effective date of the modification.

OUT-OF-AREA SERVICES

Overview

Keystone Health Plan East, Inc. ("Keystone") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever the Member obtains healthcare services outside of Keystone’s Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When the Member receives care outside of Keystone’s Service Area, they will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield in that geographic area ("Host Blue"). Some providers (“non-participating providers”) don’t contract with the Host Blue. Keystone explains below how we pay both kinds of providers.

Keystone covers only limited healthcare services received outside of our Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care, Urgent Care and Follow-up Care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the Member's Primary Care Physician ("PCP").

A. **BlueCard® Program**
   Under the BlueCard® Program, when a Member obtains Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Keystone will remain

responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables the Member to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to fill out. The Member will be responsible for the Copayment amount, as stated in the ***Schedule of Cost Sharing & Limitations***.

Emergency Care Services: If the Member experiences a Medical Emergency while traveling outside Keystone's Service Area, go to the nearest Emergency or Urgent Care facility.

When the Member receives Out-of-Area Covered Healthcare Services outside Keystone's Service Area and the claim is processed through the BlueCard Program, the amount the Member pays for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the Member's Covered Services; or
- The negotiated price that the Host Blue makes available to Keystone.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's 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 also take into account adjustments to correct for over-or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price Keystone has used for the Member's claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Keystone will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

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

1. Your Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of Keystone's Service Area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Keystone will make for the Out-of-Area Covered Healthcare Services as set forth in your Individual Agreement. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In certain situations, Keystone may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment to determine the amount Keystone will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment Keystone will make for the Out-of-Area Covered Healthcare Services as set forth in your individual Agreement.

C. BlueCard Worldwide Program

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the BlueCard Worldwide Program assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the BlueCard Worldwide Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the BlueCard Worldwide Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact Keystone to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

D. **Areas Served by the BlueCard or Guest Membership Programs**

The BlueCard Program's Urgent and Follow-Up Care benefits are available from providers contracting with the Blue Cross and Blue Shield Association as part of its traditional network ("BlueCard Providers"). Covered Services under the Guest Membership Program are only available from providers contracting with the Blue Cross and Blue Shield Association as part of its HMO Networks. All BlueCard and Guest Membership Covered Services must be provided by a contracting provider, in the respective networks of providers, unless Preapproved by the HMO or, in the case of Guest Membership services,

the Host HMO. Even when the Member is traveling in a geographic area not served by a contracting BlueCard Provider, coverage will be provided anywhere in the fifty (50) states for Emergency and Urgent Care. Urgent Care and Follow-Up Care are available in selected geographic locations in all states and the District of Columbia. Guest Membership registration is available in selected geographic areas. To find out if Urgent Care or Follow-Up Care is available in a specific travel destination, the Member should call 1-800-810-BLUE (TTY: 711). For availability of Guest Membership, the Member should call the Guest Membership Coordinator.

E. **Grievances And Appeals For BlueCard And Guest Membership Services**
If the Member has a problem or concern about the services or Benefits received through the BlueCard or Guest Membership Programs the Member has the same right to file a Grievance or to appeal a coverage decision as when in the HMO Service Area and receiving care from the HMO Providers. The HMO will retain responsibility for Benefits provided through the BlueCard and Guest Membership Programs. Refer to the Grievance and Appeals section for a complete explanation of the process and procedure for filing a Grievance or an appeal. When filing a Grievance or appeal involving BlueCard or Guest Membership Services, the Member should identify that the BlueCard or Guest Membership Program was being used and indicate which of its specific services (Urgent Care, Follow-Up Care, or the Guest Membership) are at issue.

F. **Transfer Of Medical Information**
The "Transfer of Medical Information" form must be completed prior to accessing Guest Membership Benefits. This form is the primary means by which the Member's medical information is communicated between the HMO and the Host HMO. This form will assist Providers in coordinating the Member's care during the time away from home and upon return. After the Member has completed and signed the "Transfer of Medical Information" form, the form will be completed by the HMO or the Host Primary Care Physician, as appropriate. The form will be processed through the Guest Membership Program. A Guest Membership Coordinator is responsible for forwarding the form between the HMO and Host HMO. Failure to sign and date the "Transfer of Medical Information" form will result in a denial of Guest Membership Benefits.

POLICIES AND PROCEDURES

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

PREMIUM RATE AND BENEFIT PROVISIONS

The premium rates for this Agreement shall be in accordance with the rating methodology filed with and approved by the Insurance Department of the Commonwealth of Pennsylvania. Premium rates for this Agreement are based on a member-level buildup using a per member per month base rate adjusted for the customer’s member-specific characteristics of age, geographic area and tobacco use.

In consideration of these payments to the HMO, the HMO agrees to provide access to medical and Hospital Covered Services and other benefits as specified in this Subscriber Agreement for eligible persons who enroll hereunder, in accordance with the terms, conditions, Limitations and exclusions of this Subscriber Agreement.

PREMIUM RATE CHANGES

Premium rates may be changed prospectively with the prior approval of the Pennsylvania Insurance Department during any consecutive 12-month period in which this Agreement remains in effect, provided that prior written notice of such proposed change shall be given to the Subscriber by the HMO.

Payment of the new premium by the Subscriber shall be considered receipt of notice and acceptance of the changed premium rate.

PRESCRIPTION DRUG REBATE DISCLOSURE

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

REINSTATEMENT

Any Member whose membership shall have been terminated may be reinstated up to thirty (30) days after the last date of the grace period if the Subscriber applies for reinstatement, and the HMO receives payment of the premium required for reinstatement. The HMO and Members have the same rights under the reinstated Agreement as they had under the Agreement immediately before the due date of the defaulted premium. The right of the Applicant to have this Agreement reinstated is limited to one (1) reinstatement within a 12-month period, and two reinstatements per lifetime.

After thirty (30) days, the Applicant must re-apply for coverage under this plan by completing a new Application/Change Form. The Effective Date of Coverage for an Applicant will be the first of the month following approval of the Application/Change Form by the HMO and timely payment of the appropriate rate. Upon acceptance of the Application/Change Form by the HMO, the Applicant and eligible Dependents shall be subject to all the terms of the new Agreement.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

Keystone is an independent corporation operating under a license from Blue Cross and Blue Shield Association, a national association of independent Blue Cross and Blue Shield Plans (the "Association"). Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Keystone to use the Blue Cross and Blue Shield words and symbols. Keystone, which is entering into this Agreement, is not contracting as an agent of the

Association. Only Keystone shall be liable for any of the obligations under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Keystone other than those obligations created under other provisions of this Agreement.

STATUS CHANGE

Applications for changes in contract type or additions or deletions of eligible Dependents shall be filed on Application/Change Forms supplied by the HMO and shall become effective and a part of this Subscriber Agreement upon acceptance by the HMO. See Section EL – Eligibility, Change And Termination Rules Under The Plan.

TIME LIMIT ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Agreement, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Agreement, shall be used to void said Agreement or to deny benefits for a loss Incurred commencing after the expiration of such three (3) year period. A new three (3) year contestable period applies to each new Dependent added to the coverage provided under this Agreement as of the Dependent's Effective Date of Coverage. No claim for loss Incurred shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of Coverage under this Agreement.

SECTION SC - SCHEDULE OF COST SHARING & LIMITATIONS

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

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

Your Primary Care Physician or Referred Specialist must obtain Preapproval from the HMO to confirm the HMO's coverage for certain Covered Services. If your Primary Care Physician or Referred Specialist provides a Covered Service or Referral without obtaining the HMO's Preapproval, you are not responsible for payment for that Covered Service. To access a complete list of services that require Preapproval, log onto the HMO website, at www.ibx.com/preapproval or you can call Customer Service at the phone number listed on your ID Card to have the list mailed to you.

Benefit Period: Your Benefit Period is a Calendar Year (1/1 – 12/31).

OUT-OF-POCKET MAXIMUM	
Per Member	$4,000
Per Family	$8,000

The Out-of-Pocket Maximum is the maximum dollar amount that a Member pays for Covered Services within a Benefit Period. The Out-of-Pocket Maximum includes Copayments and Coinsurance amounts for Essential Health Benefits; it does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Subscriber Agreement.

LIFETIME BENEFIT MAXIMUM	Unlimited

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
OFFICE VISITS TO YOUR PCP (Non-Preventive) (Includes Retail Clinic Visits, Home Visits and Outpatient Consultations)	$15 per Provider, per date of service
OFFICE VISITS TO A SPECIALIST	$30 per Provider, per date of service
PEDIATRIC PREVENTIVE CARE	$0
IMMUNIZATIONS	$0
ADULT PREVENTIVE CARE **Routine/Preventive Colonoscopy** Providers that are not Hospital based Providers that are Hospital based*	$0 $0 $750 per procedure
Note for Routine/Preventive Colonoscopy: *The Hospital based Copayment will be waived if your Primary Care Physician determines that it would be medically inappropriate to have the preventive colonoscopy service provided in the ambulatory setting. There is no cost share applied if your preventive colonoscopy service is performed at a facility that is not Hospital based (for example, an Ambulatory Facility); if your preventive colonoscopy service is performed at a Hospital based facility, the Hospital based copayment shown above will apply.	
WOMEN'S PREVENTIVE HEALTH CARE (Includes Routine Gynecological Exam, Pap Smear, one (1) per Benefit Period, all ages)	$0
MAMMOGRAMS	$0
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT	$0
Six (6) Outpatient nutrition counseling visits/sessions per Benefit Period	
SMOKING CESSATION	$0
INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
HOSPITAL SERVICES*	$400 per day, up to maximum $2,000 per admission
MEDICAL CARE **Inpatient Professional Services**	$0
SKILLED NURSING CARE FACILITY*	$200 per day, up to maximum $1,000 per admission
Maximum of One hundred twenty (120) Inpatient days per Benefit Period.	

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
ALCOHOL OR DRUG ABUSE AND DEPENDENCY TREATMENT (including Detoxification)	
Inpatient Alcohol Or Drug Abuse And Dependency Treatment Admissions*	$400 per day, up to maximum $2,000 per admission
Outpatient Alcohol Or Drug Abuse And Dependency Treatment Service/Occurrence	$30 per Provider, per date of service
BLOOD	10% of the Allowed Amount
HOSPICE SERVICES	
Inpatient Hospice Services	$0
Outpatient Hospice Services	
Professional Service	$0
Facility Service for Respite Care	$0
Respite Care is provided for a maximum of seven (7) days every six (6) months.	
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES	
Artificial Insemination	$30 per Provider, per date of service
Maternity/Obstetrical Care	
Professional Service	$30, first visit only
Facility Services *	$400 per day, up to maximum $2,000 per admission
Elective Abortion	
Professional Service	$30 per Provider, per date of service
Outpatient Facility Services	
Ambulatory Surgical Facility	$100 per procedure
Outpatient Hospital-Based Facility	$300 per procedure

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES (continued)	
Newborn Care	$0
MENTAL HEALTH CARE **Inpatient Mental Health Care Admissions** *	$400 per day, up to maximum $2,000 per admission
Outpatient Mental Health Care Service/Occurrence	$30 per Provider, per date of service
SERIOUS MENTAL ILLNESS HEALTH CARE	
Inpatient Serious Mental Illness Health Care Admissions *	$400 per day, up to maximum $2,000 per admission
Outpatient Serious Mental Illness Health Care Service/Occurrence	$30 per Provider, per date of service
SURGICAL SERVICES **Inpatient Professional Services**	$0
Outpatient Facility Charges **Ambulatory Surgical Facility** **Outpatient Hospital-Based Facility**	 $100 per day $300 per day
Outpatient Anesthesia	$0
Voluntary Second Surgical Opinion	$30 per opinion
If more than one (1) surgical procedure is performed by the same Professional Provider during the same operative session, the HMO will pay 100% of the contracted fee schedule amount, less any required Member Copayments, for the highest paying procedure and 50% of the contracted fee schedule amount for each additional procedure.	

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
TRANSPLANT SERVICES	
Inpatient Transplant Services	$400 per day, up to maximum $2,000 per admission
Outpatient Transplant Services	$100 per procedure

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATION**
AMBULANCE	
Emergency Transport	$50 per destination
Non-Emergency Transport	$100 per destination
DAY REHABILITATION PROGRAM	
Outpatient Visits Thirty (30) visits per Benefit Period	10% of the Allowed Amount
DENTAL, ACCIDENTAL INJURY	10% of the Allowed Amount
DIABETIC EDUCATION PROGRAM	$0
DIABETIC EQUIPMENT AND SUPPLIES	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
DIAGNOSTIC SERVICES	
Routine Radiology/Diagnostic Services (includes Allergy Testing)	$30 per date of service
Non-Routine Diagnostic Services (including MRI/MRA, CT/CTA scans, PET scans)	$60 per date of service

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
DIAGNOSTIC SERVICES (continued)	
Sleep Studies performed at Home and Freestanding Facility	$100 per date of service
Sleep Studies performed at Outpatient Hospital-Based Facility	$300 per date of service
DURABLE MEDICAL EQUIPMENT (including PROSTHETIC DEVICES and ORTHOTICS)	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
EMERGENCY CARE – Facility	$250 per service/ occurrence
The emergency room Copayment will be the PCP office visit Copayment if you notify us that you were directed to the emergency room by your Primary Care Physician or the HMO, and the services could have been provided in your Primary Care Physician's office.	
HABILITATIVE SERVICES	
Physical/Occupational Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
Speech Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
HOME HEALTH CARE	10% of Allowed Amount
Maximum of Sixty (60) visits per Benefit Period. Special or Private Duty Nursing Not Included.	
INJECTABLE MEDICATIONS **Standard Injectable Drugs** **Specialty Drugs**	 $0 $60 per visit
LABORATORY AND PATHOLOGY TESTS	$0

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
MEDICAL CARE **Outpatient Professional Services**	$0
MEDICAL FOODS AND NUTRITIONAL FORMULAS	10% of the Allowed Amount
REHABILITATIVE SERVICES	
Physical Therapy/Occupational Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
There is no visit limit for lymphedema therapy related to a mastectomy.	
Speech Therapy	$30 per Provider, per date of service
Thirty (30) visits per Benefit Period	
SPINAL MANIPULATION THERAPY	$50 per Provider, per date of service
Twenty (20) visits per Benefit Period	
THERAPY SERVICES **Cardiac Rehabilitation Therapy** Thirty-six (36) visits per Benefit Period	$30 per Provider, per date of service
Chemotherapy	$30 per Provider, per date of service
Dialysis	$30 per Provider, per date of service
Infusion Therapy	$30 per Provider, per date of service
Pulmonary Rehabilitation Therapy Thirty-six (36) visits per Benefit Period	$30 per Provider, per date of service
Radiation Therapy	$30 per Provider, per date of service
Respiratory Therapy	$30 per Provider, per date of service

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATION**
URGENT CARE CENTER - Facility	$100 per Provider, per date of service

BENEFIT	FOR BENEFITS PROVIDED BY MDLIVE®:
Telemedicine Services Provided by MDLIVE®	$40 fee per Provider per date of service

Inpatient Copayment Waiver Provision
*The Inpatient Copayment as stated in this Schedule applies to each admission, readmission or transfer of a Member for Covered Services for Inpatient treatment of any condition. For purposes of calculating the total Copayment due, any admission occurring within ten (10) days of discharge from any previous admission shall be treated as part of the previous admission.

PRESCRIPTION DRUG COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Participating Retail Pharmacy	
Generic Drug	$5
Preferred Brand Drug	$40
Non-Preferred Drug	$70
Specialty Drug	50% for Covered Drugs or Supplies up to a Prescription Cost Sharing Maximum (member cost share maximum) of $700

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Participating Mail Service Pharmacy	
The amount of your cost sharing is determined by the days-supply you receive of a Covered Maintenance Drug:	
For a 1-30 days-supply:	
Generic Drug	$5
Preferred Brand Drug	$40
Non-Preferred Drug	$70
For a 31-90 days-supply:	
Generic Drug	$10
Preferred Brand Drug	$80
Non-Preferred Drug	$140
Non-Participating Pharmacy	Member pays 70% of Allowed Amount for Covered Drugs or Supplies.

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (continued)

PRESCRIPTION DRUG LIMITATIONS

A description of limitations for your Covered Drugs Or Supplies is described below:

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

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

   Up to a ninety (90) day supply of a Maintenance Prescription Drug may be obtained through a Participating Mail Service Pharmacy**.**

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

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

5. Members must present their Identification Card, and the existence of Prescription Drug coverage must be indicated on the card.

6. A Member shall pay to a Participating Pharmacy:

   A. One hundred percent (100%) of the cost for a Prescription Drug dispensed when the Member fails to show his or her Identification Card. A claim for reimbursement for Covered Drugs Or Supplies may be submitted to the HMO; or
   B. One hundred percent (100%) of a non-Covered Drug or Supply; or
   C. The applicable Prescription Drug cost sharing.

7. In certain cases the HMO may determine that the use of certain Covered Drugs or Supplies for a Member’s medical condition requires prior authorization for Medical Necessity.

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

Note for Prescription Drug shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained at a Participating Pharmacy or a Participating Mail Service Pharmacy for generic products and for certain brand products when a generic alternative or equivalent to the brand product does not exist. All other Brand contraceptive products are covered at standard cost-sharing as reflected in this Section SC - Schedule of Cost Sharing & Limitations.

PEDIATRIC VISION COST SHARING & LIMITATIONS	
BENEFIT	**COST SHARING/LIMITATIONS**
VISION CARE	
Participating Provider	
Routine Eye Exam & Refraction	$0 Once every Benefit Period
Frames and Prescription Lenses	$0 Once every Benefit Period
Elective Contact Lenses (in lieu of eyeglasses)	$0, at participating independent providers for Davis collection contacts
Elective Contact Lenses Fitting and Follow-up Care	15% discount, not available at all Participating Providers.
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	$0
Non-Participating Provider	Not Covered

PEDIATRIC DENTAL COST SHARING & LIMITATIONS	
DENTAL DEDUCTIBLE: $50 per eligible Member must be met before applicable Coinsurance amounts are applied, unless noted otherwise below.	
BENEFIT	**COST SHARING/LIMITATIONS**
Oral Evaluations (Exams)	0% Dental deductible does not apply
Radiographs (All X-Rays)	50% Dental deductible does not apply
Prophylaxis (Cleanings)	0% Dental deductible does not apply
Fluoride Treatments	0% Dental deductible does not apply
Palliative Treatment (Emergency)	50% Dental deductible does not apply
Sealants	0% Dental deductible does not apply

PEDIATRIC DENTAL COST SHARING & LIMITATIONS (continued)	
BENEFIT	**COST SHARING/LIMITATIONS**
Other Diagnostic & Preventive Services	Not Covered
Space Maintainers	50%
Amalgam Restorations (Metal fillings)	50%
Resin-based Composite Restorations (White fillings)	50%
Crowns, Inlays, Onlays	50%
Crown Repair	50%
Endodontic Therapy (Root canals, etc.)	50%
Other Endodontic Services	50%
Surgical Periodontics	50%
Non-Surgical Periodontics	50%
Periodontal Maintenance	50%
Prosthetics (Complete or Fixed Partial Dentures)	50%
Adjustments and Repairs of Prosthetics	50%
Other Prosthetic Services	50%
Maxillofacial Prosthetics	Not Covered
Implant Services	50%
Simple Extractions	50%
Surgical Extractions	50%
Oral Surgery	50%
General Anesthesia, Nitrous Oxide and/or IV Sedation	50%
Consultations	0% Dental deductible does not apply
Adjunctive General Services	Not Covered
Medically Necessary Orthodontics*, with the HMO's prior approval and a written plan of care	50%

*There is a 12 month Waiting Period applicable to Medically Necessary Orthodontics

Note For Waiting Period:
The waiting period for certain benefits to be payable under this plan will not be satisfied until twelve (12) months of the contract year have expired and a renewal of the plan will be necessary to fairly access the benefits.

PEDIATRIC DENTAL LIMITATIONS:

Covered Services are limited as detailed below. For Covered Services listed below that apply an age limitation, those services are covered until 12:01 a.m. of the birthday when the patient reaches the age as stated.

All benefits under this plan end at the end of the calendar year in which the child turns age 19.

1. Full mouth x-rays – one (1) every five (5) year(s).

2. Bitewing x-rays – one (1) set(s) per six (6) months.

3. Oral Evaluations:

   - Comprehensive, periodic and limited problem focused – one (1) of these services per six (6) months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
   - Consultations – one (1) of these services per Dentist per patient per twelve (12) months for a consultant other than a Pedodontist or Orthodontist.
   - Detailed problem focused – one (1) per Dentist per patient per twelve (12) months per eligible diagnosis.

4. Prophylaxis – one (1) per six (6) months. One (1) additional for Members under the care of a medical professional during pregnancy.

5. Topical fluoride treatment – two (2) per twelve (12) months.

6. Fluoride varnish – two (2) per twelve (12) months.

7. Space maintainers – one (1) per five (5) year period for Members under age fourteen (14) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.

8. Sealants – one (1) per tooth per 36 months.

9. Preventive resin restorations – one (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.

10. Prefabricated stainless steel crowns – one (1) per tooth per 36 months.

11. Periodontal Services:

   - Full mouth debridement – one (1) per lifetime.
   - Periodontal maintenance following active periodontal therapy – four (4) per twelve (12) months in addition to routine prophylaxis.
   - Periodontal scaling and root planing – one (1) per twenty-four (24) months per area of the mouth.
   - Surgical periodontal procedures – one (1) per thirty-six (36) months per area of the mouth.
   - Guided tissue regeneration – one (1) per tooth per lifetime.

12. Replacement of restorative services only when they are not, and cannot be made, serviceable:

   - Basic restorations – not within twenty-four (24) months of previous placement.
   - Single crowns, inlays, onlays – not within five (5) years of previous placement.
   - Buildups and post and cores – not within five (5) years of previous placement.
   - Replacement of natural tooth/teeth in an arch – not within five (5) years of a fixed partial denture, full denture or partial removable denture.

13. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within six (6) months of insertion by the same Dentist. Subsequent denture relining or rebasing limited to one (1) every three (3) years thereafter.

14. Pulpal therapy – one (1) per eligible tooth per lifetime. Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

15. Root canal retreatment – one (1) per tooth per lifetime.

16. Recementation – one (1) per five (5) years. Recementation during the first twelve (12) months following insertion by the same Dentist is included in the prosthetic service benefit.

17. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).

18. Therapeutic drug injections – only covered in unusual circumstances, by report.

19. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the Dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the Dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed under this ABP.

20. Payment for orthodontic services shall cease at the end of the month after termination by the HMO.

Medically Necessary Orthodontics Coverage:

In this section, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician or Dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with the generally accepted standards of medical/dental practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient or physician/Dentist, 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.

As used in subpart 1, above, "generally accepted standards of medical/dental practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical/dental literature generally recognized by the relevant professional community;
- recognized Medical/Dental and Specialty Society recommendations;
- the views of physicians/Dentists practicing in the relevant clinical area; and
- any other relevant factors.

A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

Coverage of Medically Necessary Orthodontics:

1. Orthodontic treatment must be Medically Necessary and be the only method capable of:
   a) Preventing irreversible damage to the Member's teeth or their supporting structures and,
   b) Restoring the Member's oral structure to health and function.
2. Members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Medically Necessary orthodontic services.

3. All Medically Necessary orthodontic services require prior approval and a written plan of care.

Predetermination

A predetermination is a request for the HMO to estimate benefits for a dental treatment the Member has not yet received. In a predetermination review, the HMO looks at patient eligibility, Dental Necessity and the Agreement's coverage for the treatment. Predetermination is not required for any benefits under the Agreement. Payment of benefits for a predetermined service is subject to the Member's continued eligibility in the Agreement. At the time the claim is paid, the HMO may also correct mathematical errors, apply coordination of benefits, and make adjustments to comply with the Member's current Agreement and Out-of-Pocket Maximums on the date of service.

Review of a Benefit Determination

If the Member is not satisfied with a benefit determination or payment, the Member should contact the HMO's Customer Service Department at the toll-free telephone number on their ID card. If, after speaking with a Customer Service representative, the Member is still dissatisfied, refer to the Resolving Problems section of this Agreement for further steps the Member can take regarding their claim.

IMPORTANT NOTICES

Regarding Non-Discrimination Rights

The Member has the right to receive health care services without discrimination:

- based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity;
- for medically necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- related to gender transition if such denial or limitation results in discriminating against a transgender individual.

2017 PREVENTIVE SCHEDULE

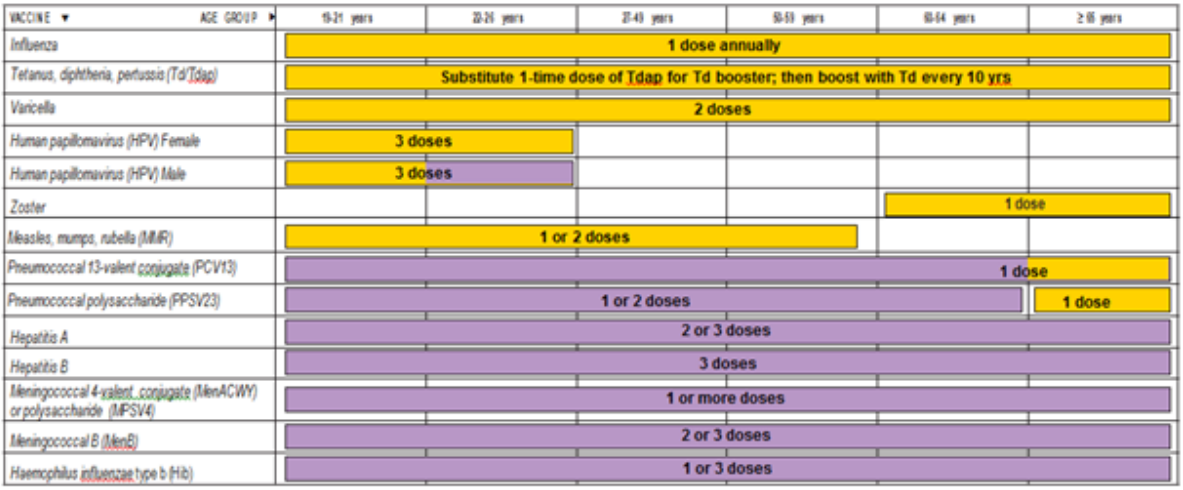
This schedule is a reference tool for planning your preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your health care provider is always your best resource for determining if you're at increased risk for a condition. Some services may require precertification/preapproval. If you have questions about this schedule, precertification/preapproval, or your benefit coverage, please call the Customer Service number on the back of your ID card.

PREVENTIVE CARE SERVICES FOR ADULTS

VISITS	
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: • High blood pressure screening • Behavioral counseling for skin cancer	One exam annually for all adults
SCREENINGS	
Adult abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males age 65 to 75 years with a history of smoking
Alcohol and drug use/misuse screening and behavioral counseling intervention	Screening for all adults Behavioral counseling in a primary care setting for adults with a positive screening result for drug or alcohol use/misuse
Colorectal cancer screening	Adults age 50 to 75 years using any of the following tests: • Fecal occult blood testing: once a year • Highly sensitive fecal immunochemical testing: once a year • Flexible sigmoidoscopy: once every five years • Barium enema: once every five years • CT colonography: once every five years • Stool DNA testing: frequency of testing should be discussed with health care provider • Colonoscopy: once every 10 years

Depression screening	Annually for all adults
Hepatitis B virus (HBV) screening	All asymptomatic adults at high risk for HBV infection
Hepatitis C virus (HCV) screening	All asymptomatic adults age 18 years and older or as a one-time screening for adults born between 1945 and 1965
Human immunodeficiency virus (HIV) screening	All adults
Lipid disorder screening	Every five years for males age 35 years and older For adults age 20 years and older with an increased risk for coronary artery disease, screening is covered at shorter intervals
Lung cancer screening	Adults age 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years
Obesity screening and behavioral intervention	Obesity screening for all adults Behavioral intervention for adults with a body mass index (BMI) of 30 kg/m^2 or higher
Syphilis infection screening	All adults at increased risk for syphilis infection
Abnormal blood glucose and Type 2 diabetes mellitus screening and intensive counseling interventions	Abnormal blood glucose and type 2 diabetes screening for adults 40 to 70 years who are overweight or obese Intensive behavioral counseling interventions for individuals 40 to 70 years who are overweight or obese with abnormal blood glucose up to 24 sessions per year
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults age 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors
Nutritional counseling for weight management	6 visits per year
Counseling for the prevention of falls	Community-dwelling adults age 65 years and older with an increased risk of falls
Tobacco use and tobacco-caused disease counseling	All adults who use tobacco products
MEDICATIONS	
Aspirin	Adults 50-69 years for the primary prevention of cardiovascular disease and colorectal cancer
Tobacco cessation medication	All adults who use tobacco products
Vitamin D	Community-dwelling adults age 65 years and older with an increased risk of falls

IMMUNIZATIONS



PREVENTIVE CARE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

VISITS	
Well-woman visits Services that may be provided during the well-woman visit include but are not limited to the following: • BRCA-related cancer risk assessment • Discussion of chemoprevention for breast cancer • Intimate partner violence screening • Primary care interventions to promote and support breastfeeding • Recommended preventive preconception and prenatal care services • Tobacco use counseling	At least annually
SCREENINGS	
Bacteriuria screening	All asymptomatic pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic women with either personal history or family history of a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling
Breast cancer screening (2D or 3D mammography)	All women age 40 years and older
Cervical cancer screening (Pap test)	Ages 21 to 65: Every three years Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval
Chlamydia screening	Sexually active women age 24 years and younger or older sexually active women who are at increased risk for infection
Depression Screening	All pregnant and post-partum women
Gestational diabetes mellitus screening	Asymptomatic pregnant women after 24 weeks of gestation or at the first prenatal visit for pregnant women identified to be at high risk for diabetes
Gonorrhea screening	Sexually active women age 24 years and younger or older sexually active women who are at increased risk for infection
Hepatitis B virus (HBV) screening	All pregnant women or asymptomatic adolescents and adults at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All pregnant women

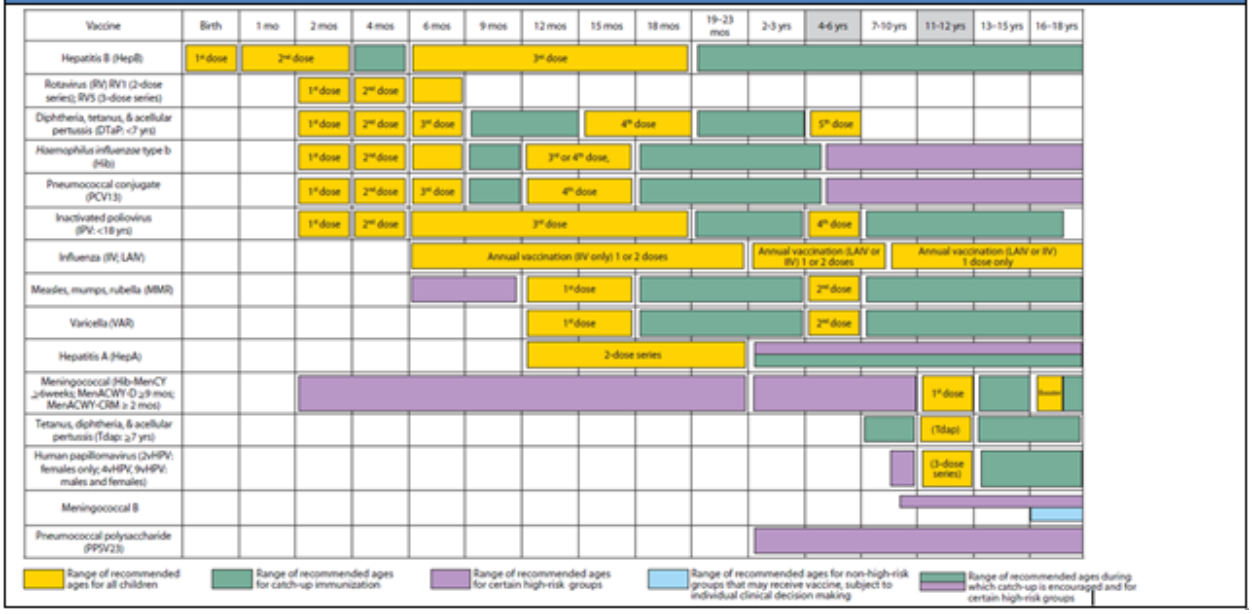
Human papillomavirus (HPV) screening	Age 30 and older: Every three years Ages 30 to 65: Every five years with a combination of Pap test and HPV testing, for those that want to lengthen the screening interval
Iron-deficiency anemia screening	All asymptomatic pregnant women
Osteoporosis (bone mineral density) screening	Every two years for women younger than 65 years who are at high risk for osteoporosis Every two years for women 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition
Syphilis screening	All pregnant women at first prenatal visit For high-risk pregnant women, repeat testing in the third trimester and at delivery Women at increased risk for syphilis infection
MEDICATIONS	
Aspirin	Low-dose aspirin for pregnant women who are at high risk for preeclampsia after 12 weeks of gestation
Breast cancer chemoprevention	Asymptomatic women age 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention
Folic Acid	Daily folic acid supplements for all women planning for or capable of pregnancy
MISCELLANEOUS	
Breastfeeding supplies/support/counseling	Comprehensive lactation support/counseling for all pregnant women and during the postpartum period Breastfeeding supplies
Reproductive education and counseling, contraception, and sterilization	All women with reproductive capacity

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pre-birth exams	All expectant parents for the purpose of establishing a pediatric medical home
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: • Behavioral counseling for skin cancer prevention • Blood pressure screening • Congenital heart defect screening • Counseling and education provided by healthcare providers to prevent initiation of tobacco use • Developmental surveillance • Dyslipidemia risk assessment • Hearing risk assessment for children 29 days or older • Height, weight, and body mass index measurements • Hemoglobin/hematocrit risk assessment • Obesity screening • Oral health risk assessment • Psychosocial/behavioral assessment	All children up to 21 years of age, with preventive exams provided at: • 3-5 days after birth • By 1 month • 2 months • 4 months • 6 months • 9 months • 12 months • 15 months • 18 months • 24 months • 30 months • 3 years-21 years: annual exams
SCREENINGS	
Alcohol and drug use/misuse screening and behavioral counseling intervention	Annually for all children 11 years of age and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
Autism and developmental screening	All children during the 18 month and 24 month preventive exams
Chlamydia screening	All sexually active children up to age 21 years
Depression screening	Annually for all children age 11 years to 21 years
Dyslipidemia screening	Following a positive risk assessment or in children where laboratory testing is indicated
Gonorrhea screening	All sexually active children up to age 21 years
Hearing screening for newborns	All newborns
Hearing screening for children 29 days or older	Following a positive risk assessment or in children where hearing screening is indicated
Hepatitis B virus (HBV) screening	All asymptomatic adolescents at high risk for HBV infection

Human immunodeficiency virus (HIV) screening	All children
Lead poisoning screening	All children at risk of lead exposure
Newborn metabolic screening panel (eg, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	All newborns
Syphilis screening	All sexually active children up to age 21 years
Visual impairment screening	All children up to age 21 years
ADDITIONAL SCREENING SERVICES AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	Semiannually for all sexually active adolescents at increased risk for sexually transmitted infections
MEDICATIONS	
Fluoride	Oral fluoride for children age 6 months to 5 years whose water supply is deficient in fluoride
Iron	Asymptomatic children age 6 to 12 months who have an increased risk of iron deficiency anemia
Prophylactic ocular topical medication for gonorrhea	All newborns within 24 hours after birth
MISCELLANEOUS	
Fluoride varnish application	Twice a year for all infants and children starting at age of primary tooth eruption to 5 years of age
Hemoglobin/hematocrit testing	Following a positive risk assessment or in children where laboratory testing is indicated for children up to age 21 years
Tuberculosis testing	All children up to age 21 years

IMMUNIZATIONS (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)



EFFECTIVE September 23, 2013

INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION[1]

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross[2] values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

Note: "Protected health information" or "PHI" is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

[1] If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group's privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

[2] For purposes of this Notice, "Independence Blue Cross" refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc. independent licensees of the Blue Cross and Blue Shield Association

This revised Notice takes effect on September 23, 2013, and will remain in effect until we replace or modify it.

Copies of this Notice

You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice

The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law

The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)

In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclosure information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other Independence Blue Cross affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use

and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available Independence Blue Cross health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose "summary health information" to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor's group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct audits and investigations of the health care system, to determine eligibility for government programs, to

determine compliance with government program standards, and for certain civil rights enforcement actions.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers' compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a "designated record set." Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called "Your Privacy Rights Concerning Your Protected Health Information."

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed Independence Blue Cross Personal Representative Designation Form or documentation that supports the person's qualification according to state law (such as a power of attorney or guardianship). To request the Independence Blue Cross Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved Independence Blue Cross Authorization Form. To request the Independence Blue Cross Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)
You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved Independence Blue Cross form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross’s vendors (known as "Business Associates").request to amend your

PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will **not** include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- before April 14, 2003.

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

Right to a Notification of a Breach of your PHI: You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Your Right to File a Privacy Complaint
If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross's privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your ID Card, or you may contact the Privacy Office as follows:

Independence Blue Cross
Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 - 1762

Fax: (215) 241-4023 or 1-888-678-7006 (toll free)
E-mail: Privacy@ibx.com
Phone: 215-241-4735 or 1-888-678-7005 (toll free)

Hearing-impaired TTY users may call 711 to receive assistance free of charge.

Para obtener asistencia en Español, por favor comuníquese con el Servicio de Atención al Cliente al número que figura en su tarjeta de identificación.

Upang makakuha ng tulong sa Tagalog, tumawag sa numero ng telepono ng serbisyong pangkostumer na nakalista sa iyong card ng pagkikilanlan.

要取得中文協助，請撥打列示在您身份證上的客戶服務電話。

Táá Diné k'ehjí shíka 'adoowoł nínízingo, ninaaltsoos bee ééhózinígíí béésh bee hane'é bikáá' bee bik'e'ashchínígíí bich'i' hodíílnih.

An Important Message about a Policy Change to Protect Your Privacy

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), Independence Blue Cross allows its members the right to authorize a third party to receive their protected health information by completing a HIPAA authorization form.

Previously, the IBC HIPAA authorization form explained that your authorization would automatically expire six months after your coverage with IBC ends. We have made a change to this policy and your authorization will no longer expire unless you revoke it in writing.

If you have any questions regarding this new policy, please contact our Customer Service Department by calling the telephone number on the back of your health insurance identification card.

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross – Independent licensees of the Blue Cross and Blue Shield Association.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.