Independence

Keystone Health Plan East



BENEFITS BOOK

How your health plan works
HMO Proactive

IBX

Never stop caring

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Welcome to Independence Blue Cross

We are happy to have you as an Independence Blue Cross (IBX) member! Our goal is to make it easier for you to get the care you need and manage your benefits.

This Benefits Book will help you understand your coverage so you can take full advantage of your health plan and become familiar with the benefits, services, and resources available to you.

You will find valuable information about:

- How to select a primary care physician (PCP)
- What services are and are not covered by your health insurance
- How decisions are made about what is covered
- Your member account at **ibx.com** and the IBX app
- How to get in touch with us if you have a problem

If you have any questions, call Customer Service at the number on the back of your member ID card and we will be happy to help.

Thank you for being an IBX member. We look forward to providing you with quality health care coverage.

Questions?

Log in at **ibx.com**. You can also call the number on the back of your member ID card or **1-800-ASK-BLUE (1-800-275-2583) (TTY: 711)** to speak to a Customer Service representative.

Introduction to your health plan

What is a primary care physician?

You have a Keystone HMO Proactive health plan, which means you and your covered dependents are required to select a primary care physician, or PCP. Your PCP is the doctor who will treat your general health needs and coordinate your care by providing referrals, when necessary.

All network providers are required to provide coverage 24 hours a day, 7 days a week, either in the office or by on-call/answering services. However, you may also choose to use an alternative, such as virtual care, urgent care, or retail clinic.

When you need to see a specialist, such as a cardiologist or dermatologist, your PCP will refer you to an in-network doctor. Note: Referrals are not needed for some services, including gynecology, mammograms, behavioral health, and emergency care.

In addition, your PCP has designated providers for lab services (e.g., blood work), radiology (e.g., X-rays), and physical and occupational therapy. You will need to visit those providers when you need any of these services.

How to choose or change your PCP

There are two ways to choose or change your PCP:



Online: Log in at ibx.com, our easy-to-use secure member website, to choose or change your PCP.



Phone: Call 1-800-ASK-BLUE (1-800-275-2583; TTY: 711) and one of our Customer Service representatives will help you update your PCP.

With Keystone HMO Proactive, you can save money

Keystone HMO Proactive health plans use a tiered network. You can visit any doctor or hospital in the network, but now you have the opportunity to save even more on out-of-pocket costs when you visit certain health care providers.

Here's how it works: We grouped our provider network into three tiers based on cost and, in many cases, quality measures. While all doctors and hospitals in our network must meet high quality standards, many offer the same services at a lower cost. If they cost less, you'll pay less.

High quality doesn't have to mean high cost

Tiers help you see which providers can offer the best value on care. You'll pay the lowest out-of-pocket costs when you visit doctors and hospitals in Tier 1 – Preferred, higher costs when you use Tier 2 – Enhanced providers, and the highest costs for Tier 3 – Standard. You can choose doctors in Tier 1 – Preferred for some services, and doctors from Tiers 2 and 3 for other services.

The good news is that more than half our provider network is in Tier 1 – Preferred!

Talk with your PCP about your tiered network plan. If you need additional tests or services, your doctor can refer you to providers in Tier 1 – Preferred, or at least help you understand why he or she recommends a provider in a different tier.

Keep in mind that for some services, like surgery, you pay out-of-pocket costs for both the facility and the performing doctor. To save the most money, you'll want to make sure both are in Tier 1 – Preferred. Also, if you are admitted to an in-network hospital from the emergency room, the cost-sharing for inpatient hospital care, including medical care provided by an in-network professional provider, will apply based on the tier of the in-network hospital or professional provider.

Pay the same cost for some services, no matter where you go

There are some services that cost the same across all tiers, such as:

- Preventive care
- Emergency room
- Emergency ambulance
- Urgent care
- Prescription drugs
- Pediatric dental and vision
- Physical and occupational therapy
- Behavioral health
- Outpatient lab/pathology
- Routine radiology
- Spinal manipulation

Using your member ID card

You and your covered dependents will each receive an IBX identification (ID) card. We recommend keeping your ID card with you, as you will need to present it when you receive care. Your ID card contains information such as what you will pay when visiting your doctor, specialist, or the emergency room (ER), as well as your PCP's contact information.

You can also log in at ibx.com or using the IBX mobile app to view a digital version of your ID card or print a copy. Using the app, you can save your digital ID card to your phone's Wallet.

When you receive your ID card, call the toll-free number on the removable sticker to confirm you received it.

Get connected

When you confirm receipt of your member ID card, you will also be given the option to sign up for texts and emails from IBX. If you opt in, you will receive messages about health plan notifications, maximizing your benefits, and member-exclusive discounts and savings. Visit ibx.com/getconnected to learn more.

Locating an in-network doctor or hospital

You have access to our expansive network of doctors, specialists, hospitals, and other health care providers. Search for an in-network provider by logging in at ibx.com and using the Find a Doctor tool.

Profiles in our provider look-up tool include valuable information, such as board certifications, medical school attended, residency completion, location maps, provider specialties, race, ethnicity, languages spoken by provider, languages spoken by staff, whether the provider is accepting new patients, and more.

You can view a provider's tier placement, as long as you select *Keystone HMO Proactive* under Your Plan.

You can also call the number on the back of your member ID card and a Customer Service representative will help you locate a provider.

Rights and responsibilities

A list of your rights and responsibilities is available at ibx.com/qualitymanagement, or call Customer Service at the number on the back of your member ID card to request a paper copy.

Stay informed

Get important health plan information, health reminders, and money-saving tips and discounts sent directly to your smartphone.

Text **IBX** to **77576** to sign up.

Using your benefits to receive care

Scheduling an appointment

Call your doctor's office or use your doctor's online scheduling tool, if available, to make an appointment. If you need to cancel an appointment, be sure to notify the office at least 24 hours in advance when possible.

Access after normal business hours

Your doctor's office should offer urgent medical advice 24 hours a day, 7 days a week. If an urgent issue arises after normal business hours, call your doctor's office for instructions on how to reach your doctor or the on-call doctor. You should receive a call back within one hour.

Referrals

You are required to get a referral from your PCP for specialty services. All referrals are done electronically. You don't need a referral for gynecology care, mammograms, behavioral health, or emergency care. To view your open referrals, log in at ibx.com or using the IBX mobile app.

Services that require precertification

Precertification is an approval that your doctor must receive from us before you get coverage for certain services, genetic tests, and specialty drugs. A complete list of what requires precertification is available at ibx.com/precert. Because your care is coordinated by your PCP, all necessary precertifications will be obtained for you by your PCP.

Preventive care

Preventive care is an important part of getting and staying as healthy as possible. Our preventive care services can help you and your family avoid developing health problems and prevent minor issues from becoming major health concerns, such as diabetes and colon cancer.

Examples of preventive care services include yearly check-ups, screenings, and immunizations.

Most IBX health plans include coverage for certain designated preventive care services at no cost to you.* This means you do not have to pay copays, coinsurance, or deductibles. If a service is not considered preventive (e.g., diagnostic procedure, ongoing treatment for an existing condition) or you don't fall within the coverage guidelines, charges may apply.

For a complete list of preventive services, visit ibx.com/preventive and click on the *View IBX preventive care services* link.

Receiving care for behavioral health or substance use disorder

If you require outpatient or inpatient behavioral health or substance use disorder services, you do not need a referral from your PCP. For information on these services, call the Mental Health phone number on the back of your member ID card.

Check your health plan benefits in this book to see if you have behavioral health and substance use disorder benefits.

*Individual benefits must be verified.

Where to go for care

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, earache, cuts, rashes, sprains, and broken bones.

Visit an urgent care center for a convenient, safe, and affordable treatment alternative to emergency room care or when you can't get an appointment with your own doctor.

Retail clinic

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

Virtual care

Most health plans include the ability to see a doctor virtually for telemedicine, telebehavioral health, and teledermatology services. Virtual care increases access to care, provides an alternative option to emergency room and urgent care visits, and can reduce costs. In addition, many in-network doctors and specialists also offer their own virtual care services. Check your health plan benefits in this book to see how virtual care is covered.

Not sure what care option to use?

Go to **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 of 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 emergency room of the nearest hospital or call 911.
- In an urgent care situation, find a provider in the area. Call 1-800-810-BLUE (1-800-810-2583; 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.

Guest membership

When you know that you or a covered member of your family will be out of the area for at least 90 days, you can apply for a guest membership with a participating HMO/POS/DPOS plan in your travel area, where available.

The Away from Home Care program offers a comprehensive set of HMO/POS/DPOS benefits through a guest Blue Cross and/or Blue Shield plan while away from home.

Options include:

- **Long-term traveler:** Six months maximum; renewable upon health plan year renewal. Available to eligible subscribers and their covered dependents. This type of guest membership is typically used for long-term work assignments or for a retiree with a dual residence.
- **Families apart:** One year maximum; renewable upon expiration of guest membership. Available to subscribers' spouses or dependents who do not reside with the subscriber. The subscriber is not eligible. This type of guest membership is typically used when divorced or separated families permanently reside outside of the area.
- **Students:** One year maximum; renewable upon expiration of guest membership. Available to qualified dependents who are temporarily residing outside of the area while attending an accredited education institute. The dependent is not eligible if residing with the subscriber and is only eligible for renewal while enrolled in an accredited program until age limitation is met.

Guest members who are traveling outside of both their IBX and guest Blue Cross and/or Blue Shield plan service areas and need care should refer to and use their IBX coverage.

Guest membership coverage can go into effect 15 business days after the receipt and processing of a correctly completed and signed application. In addition, the subscriber must renew guest memberships for a spouse or dependent, if eligible, 30 days prior to the guest membership coverage period ending, or before the subscriber's benefits open enrollment date (whichever is sooner). If the subscriber's Independence coverage is cancelled at any time, the guest membership coverage will be cancelled.

Get connected with IBX at ibx.com/getconnected to receive application status updates and reminders to renew Guest Membership.

Refer to your member benefit booklet for additional information, limitations, and restrictions regarding the Away from Home Care program.

Out of town and need care?

Call **1-800-810-BLUE (1-800-810-2583; TTY: 711)** to find an in-network provider in your area.

Manage your benefits online

To manage your health plan online, all you need to do is register. Visit ibx.com/login, click *Register*, and then complete the short form.

Once you have registered for an account, you're ready to log in at ibx.com.

You can easily manage health plan benefits for you and your covered dependents:*

- View your benefits and see what is covered
- Review out-of-pocket costs and deductible amounts
- Access and organize your claims
- View, share, or order your member ID card
- Get answers about your health plan

Finding care

Looking for in-network providers? Want to see what you will pay for care? Here are some of the other resources available when you log in at ibx.com:

- Use our simple provider search tool to find in-network doctors, hospitals, labs, and other providers and see what tier they are in
- Create a custom directory of your doctors
- Estimate what you will pay for an office visit or procedure based on your benefits
- Select or change your primary care physician
- View open referrals
- Find designated sites for labs, radiology, and more

On-the-go access with the IBX app

Download the free IBX app for your iPhone or Android device to help you make the most of your health plan.

Use the IBX app to:

- View and share your ID card
- Check the status of referrals and claims
- Access benefits information
- Find doctors, hospitals, urgent care centers, and retail clinics
- Track deductibles and spending accounts
- Review your health history and prescribed medications
- Use personalized well-being tools and programs

To download the IBX app, visit the App Store or Google Play. You can log in to the app using the same username and password you use to log in at ibx.com.

One stop for the information you need

Log in at **ibx.com** or on the IBX app.

*Dependents ages 18 and older can create their own accounts.

Healthy savings

Our **Blue365**® discount program offers exclusive deals and discounts on fitness gear, gym memberships, and healthy travel experiences. Our **Blue Insider**℠ program provides exclusive deals and discounts on amusement parks, hotels, shopping, movie tickets, sporting events, and travel. Members can also earn FunLife Rewards when making eligible purchases to help offset or cover future purchases through the website. Learn more at ibx.com/discounts.

Healthy Lifestyles Rewards

Whether you're staying active, working toward a healthier weight, or quitting tobacco, Healthy Lifestyles Rewards gives you motivation (and rewards) along the way. Here's how it works:

- ✓ Log in at ibx.com to complete your wellness Health Risk Assessment.
- ✓ Get actionable next steps and access your Rewards platform.
- ✓ If you are eligible, complete an approved program and earn rewards on a reloadable Visa card that can be used at more than 77,000 participating retailers.
- ✓ Log in at ibx.com to access your Rewards platform, see your virtual wallet, and track what you've earned and spent.

Check your health plan to see if you're eligible for Healthy Lifestyles Rewards.

Connect with us

Get connected

You have the option to sign up to receive texts and emails from IBX. If you opt in, you'll get important health plan notifications, tips to maximize your benefits, and health screening reminders. Visit ibx.com/getconnected to learn more and sign up.

Find us on social media

Follow IBX on our social media channels, such as Facebook and Instagram. Our content will help you find a whole new approach to making healthy lifestyle changes, one step at a time.

- Receive health and wellness tips
- Enter contests and promotions
- Connect with other health-minded individuals
- Learn how to incorporate fitness, good nutrition, and stress management into your everyday life

Member 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 submission and status
- Requesting a new ID card
- Requesting a printed copy of your Benefits Booklet or other plan documents
- Well-being programs
- Complaint and appeal process

Language services are available

If you prefer a language other than English, call Customer Service at the number on the back of your member ID card. They will work with you through an interpreter over the phone to help you understand your benefits and answer your questions. Members can also dial 711 for Telecommunications Relay Services.



Call

Call the number on the back of your member ID card 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.



Mail

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



Visit

Independence LIVE, located at 1919 Market Street, 2nd Floor, is open Monday through Friday from 8 a.m. to 4 p.m. Visit ibx.com/events for information.

Using your prescription drug benefits

Your prescription drug plan is administered by an independent pharmacy benefits management company. The pharmacy benefits manager is responsible for maintaining a network of participating pharmacies, administering benefits, conducting prior authorization reviews, and providing customer service.

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 an in-network 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 an in-network pharmacy.
- **High level of safety.** When you fill a prescription at an in-network pharmacy, your pharmacist can identify harmful drug interactions and other dangers by viewing your drug history.
- **Mail order/home delivery and 90-day retail pharmacy options.**
  Mail order/home delivery may be available for medications you take regularly. You may also get a 90-day supply of maintenance medications at designated retail pharmacies for the same cost-share as mail order/home delivery to help make medication adherence easier and more affordable. Check your prescription drug benefits for specific details pertaining to the 90-day retail pharmacy benefit that may apply to your plan.

How to fill your prescription at a retail pharmacy

Present your ID card and your prescription at an in-network 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.

In-network pharmacies

A pharmacy is considered in-network if it is in the pharmacy network for your plan. If your plan uses the Preferred Pharmacy network, Walgreens is not an in-network pharmacy.

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 an in-network pharmacy at home.

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

To locate an in-network pharmacy, log in at ibx.com or call the Pharmacy Benefits number on the back of your ID card.

Out-of-network 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 (IBX) and/or its subsidiaries based in part on the discounted drug prices that the pharmacy benefits manager has negotiated. When you use an out-of-network 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.

Find a pharmacy

Log in at **ibx.com** or call the Pharmacy Benefits number on the back of your member ID card.

Understanding your prescription

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.

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.

To check the formulary status of drugs, log in at ibx.com.

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

- Prior authorization
- Formulary exception process
- Age and quantity limits
- Drug pricing and drug alternatives

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 doctor whether an alternative drug might be appropriate for you. Let your doctor know if you have a question about a change in prescription or if you prefer the original prescription. Your doctor 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 member ID card.

Brand vs. generic

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

Preventive drugs for adults and children

Your prescription drug plan includes 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 preventive care helps you stay healthy and may improve your overall health.

For a list of preventive drugs eligible for 100 percent coverage, visit ibx.com or call the Pharmacy Benefits number on the back of your member ID card.

If you have any questions about your prescription drug plan, call the Pharmacy Benefits number on the back of your member ID card.

Mail order/home delivery

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

Mail order/home delivery is convenient and safe to use

If you choose mail order/home delivery, 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/home delivery.

Mail order/home delivery 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 an in-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 14 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 in-network 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 use the second prescription to submit your mail order/home delivery request.*

How to request mail order/home delivery:

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/home delivery service so that you get one 90-day prescription and not three 30-day prescriptions (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 Mail Service Order Form with your first order only. Forms and envelopes are available by calling the Pharmacy Benefits number on the back of your member ID card, or you can download the form when you log in at ibx.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 to OptumRx.
4. Your mail order/home delivery request will be processed and your medication sent to you within 14 days from the day it is received, 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 provide on the form.
5. Mail order/home delivery requests can also be initiated when you log in at ibx.com.

Online services

Log in at **ibx.com** to take advantage of convenient features, such as:

- Pharmacy search
- Formulary search
- Drug pricing and drug alternatives
- Claims information
- Mail order/home delivery refill request

* Prescription drug mail order/home delivery services are administered by OptumRx Home Delivery, an independent company.

How can my doctor order a prescription for me?

Doctors can call our toll-free number to prescribe your medication(s) or submit prescriptions via fax or electronically using ePrescribing. In addition to the prescription information, your doctor must provide your member ID number, name, and date of birth. Note: To be legally valid, the fax must originate from the doctor'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/home delivery.

Paying for mail order/home delivery services

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

Mail order/home delivery refills

You can manage your prescriptions, order refills, and pay for your refills online when you log in at ibx.com.

When you receive a medication through the mail order/home delivery 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 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, call the Pharmacy Benefits 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 generally covered under your prescription drug benefits. Filling your prescription for a specialty drug via the OptumRx 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 IBX medical benefit, even if you obtained the self-injectable through the OptumRx specialty pharmacy program. However, the drug itself will be covered under your prescription drug benefit.

The self-injectable drugs covered under your medical plan include drugs that:

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

Use your vision benefits

Vision problems are among the most prevalent health issues in the United States. Three out of four adults use some form of vision correction. An eye exam can help detect vision problems, and can also help detect more serious chronic health conditions, such as diabetes, hypertension, and heart disease.

Administered by Davis Vision, your vision plan features a robust network, low out-of-pocket costs, and a variety of value-added services.

Freedom of provider choice

You have access to the national Davis Vision network, which includes more than 222,000 access points for independent eye care professionals and large retail and online providers like Visionworks, Glasses.com, and 1800Contacts.com.

Low-cost frames and lens options

You have several options to choose from for your eyewear needs:

- Select frames from the Davis Vision Exclusive Collection, which are covered in full or with a minimal copay. An interactive frame try-on tool will allow you to see what the frames look like on before purchasing them.
- Choose from any in-network independent or retail provider's own frame collection and receive an allowance. You can also use your allowance at online providers such as Glasses.com or any in-network providers that offer online services. You may have an enhanced frame allowance towards the purchase of frames at preferred sites. Please refer to your benefits for more information.

With fixed pricing on all lens styles and coatings, including blue light coatings, it's easy to predict your out-of-pocket costs. All Davis Vision Exclusive Collection frames and spectacle lenses are made in their laboratories and are warrantied against breakage for one year from the original date of dispensing.

Independence Blue Cross vision plans are administered by Davis Vision, an independent company.

Your Hearing Network products and services are made available through your coverage with Davis Vision. Your Hearing Network is not affiliated with Independence Blue Cross and does not provide Blue Cross or Blue Shield products or services. Your Hearing Network and/or Davis Vision are responsible for these products and services.



View your benefits online

Log in at ibx.com to:

- Check eligibility and plan allowances
- Locate an in-network provider

Coverage for contacts and laser vision correction

You have the option to choose contact lenses instead of eyeglasses using your allowance. You can also use your contact lens benefit allowance at 1800Contacts.com, which features an extensive collection, mail order, and discounted pricing.

If you're eligible and interested in LASIK laser vision correction services, you can receive exclusive discounted pricing and financing options from a national network of credentialed physicians.

Additional value-added services

Through your Davis Vision benefits, you have access to a free hearing exam and exclusive discounts on hearing aids, supplies, and more from Your Hearing Network.

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 any service requiring a Referral to a Provider who is not a Participating Provider. Certain benefits are subject to cost-sharing provisions such as Deductibles, 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.

This plan has a Tiered Network. Your cost share may be different based on the tier of the provider you receive services from. Participating Providers under this plan may be part of a selected subset, or tier, of the HMO's entire network of Participating Providers. Providers may be classified as Tier 1, Tier 2, or Tier 3. This plan offers three different levels of In-network benefits based on the tier designation of the Participating Provider you receive services from. Your cost sharing will be lower for use of Tier 1 Providers than for Tier 2 and Tier 3. In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be important to select a PCP and Specialist who have admitting privileges at the Tier 1 Hospital when Hospitalization becomes necessary.

Subject to the Exclusions, Copayment, Coinsurance, Benefit Maximum, and Deductible amounts, if applicable, 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 Deductibles, 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, Coinsurance, and Deductible amounts, when applicable; 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. Amounts paid for Covered Services received under Tiers 1, 2 and 3 will be applied and accumulate concurrently towards the Out-of-Pocket maximum.

SECTION SC - SCHEDULE OF COST SHARING & LIMITATIONS

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

If the Participating Provider's usual fee for a Covered Service is less than the cost sharing amount shown in this Schedule, you are only responsible to pay the Participating Provider's usual fee. The Participating Provider is required to remit any cost sharing overpayment amount 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.

This plan has a Tiered Network. For the purpose of this Program, each benefit tier (shown in the columns below) refers to your cost share based on the tier level of the Participating Provider you receive services from. Providers included in each tier (Preferred, Enhanced, or Standard) are part of a selected subset of the HMO's entire network of Participating Providers. **Section MC – Using the HMO System** provides more detail regarding Provider Tiers. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider.

Non-Participating Providers for Emergency and Out-of-Area Urgent Care Services, to the extent the Urgent Care services are Emergency services, will be reimbursed pursuant to the methodology established by the Consolidated Appropriations Act (CAA). The Member will be subject to the in-network cost-sharing levels.

To find a list of Participating Providers with their designations, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

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

	TIER 1 PREFERRED	TIER 2 ENHANCED	TIER 3 STANDARD
ANNUAL DEDUCTIBLE			
Per Member	$0	$6,000 applicable to Tiers 2 and 3	
Per Family	$0	$12,000 applicable to Tiers 2 and 3	
The Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Deductible for that Benefit Period, or the Family Deductible has been satisfied for all covered family Members combined. The Deductible under this tiered plan is an aggregate of any Deductibles paid under all Tiers for which a Deductible applies. For example, any Deductibles paid when the Member receives services from Tier 2 and Tier 3 Providers are combined to apply toward the Annual Deductible listed above.			
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
OUT-OF-POCKET MAXIMUM			
Per Member	$10,500		
Per Family	$21,000		
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 Coinsurance, Copayment and/or Deductible amounts, if applicable, 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. Amounts paid for Covered Services received under Tiers 1, 2 and 3 will be applied and accumulate concurrently towards the Out-of-Pocket maximum.			
COINSURANCE PERCENTAGE	0%	5% of the Allowed Amount	10% of the Allowed Amount
Coinsurance is applied to some of the Covered Services listed below, but not to Covered Services that require the Member to pay a Copayment amount. Coinsurance is a percentage of the Covered Service that must be paid by the Member; it is applied after the Deductible is met in each Benefit Period. A Deductible may also apply to certain services that are subject to a Copayment. Those services that are subject to a Deductible with a Copayment are identified below. The Member will also be responsible to pay costs for services that are not covered by the HMO plan.			
LIFETIME BENEFIT MAXIMUM	Unlimited		

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
OFFICE VISITS/TELEMEDICINE VISITS TO YOUR PCP (Non-Preventive)			
Office Visits (Includes Retail Clinic Visits, Home Visits and Outpatient Consultations)	$40 per Provider, per date of service	$70 per Provider, per date of service **Not** Subject to Deductible	$80 per Provider, per date of service **Not** Subject to Deductible
Telemedicine Visits (excluding Retail Clinics)	$30 per Provider, per date of service	$50 per Provider, per date of service **Not** Subject to Deductible	$55 per Provider, per date of service **Not** Subject to Deductible
Note for Office Visits/Telemedicine Visits to your PCP shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.			
OFFICE VISITS/TELEMEDICINE VISITS TO A SPECIALIST			
Office Visits	$90 per Provider, per date of service	$140 per Provider, per date of service **Not** Subject to Deductible	$150 per Provider, per date of service **Not** Subject to Deductible
Telemedicine Visits	$65 per Provider, per date of service	$100 per Provider, per date of service **Not** Subject to Deductible	$105 per Provider, per date of service **Not** Subject to Deductible
Note for Office Visits/Telemedicine Visits to a Specialist shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.			

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
PEDIATRIC PREVENTIVE CARE	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
IMMUNIZATIONS	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
ADULT PREVENTIVE CARE	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Routine/Preventive Colonoscopy			
Preventive Plus (P+) Facility/Non-Hospital based Facility**	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Non-Preventive Plus (P+) Facility/Hospital based Facility**	$750 per procedure	$750 per procedure **Not** Subject to Deductible	$750 per procedure **Not** Subject to Deductible
Note for Routine/Preventive Colonoscopy shown above: *For $0 Member cost-sharing to apply, all services must be performed by a Participating gastroenterologist or a colon and rectal surgeon. **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. In addition to seeking services from Preventive Plus Providers, colonoscopy screenings must meet the United States Preventive Services Task Force's (USPSTF) guidelines for $0 Member cost sharing to apply.			
WOMEN'S PREVENTIVE HEALTH CARE (Includes Routine Gynecological Exam, Pap Smear, one (1) per Benefit Period, all ages)	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
MAMMOGRAMS	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
NUTRITION COUNSELING	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Note for Nutrition Counseling shown above: Six (6) Outpatient nutrition counseling visits/sessions per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
SMOKING CESSATION	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
HOSPITAL SERVICES			
Inpatient and Emergency Admissions*	$600 per day, up to maximum $3,000 per admission	$900 per day, up to maximum $4,500 per admission Subject to Deductible	$1,300 per day, up to maximum $6,500 per admission Subject to Deductible

INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
MEDICAL CARE			
Inpatient Professional Service	0% of the Allowed Amount	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Inpatient Professional Services shown above: Cost-sharing does not apply to physician/surgeon fees (including Inpatient Anesthesia) that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
SKILLED NURSING FACILITY SERVICES*	$300 per day, up to a maximum of 1,500 per admission	$300 per day, up to a maximum of 1,500 per admission **Not** Subject to Deductible	$300 per day, up to a maximum of 1,500 per admission **Not** Subject to Deductible
Note for Skilled Nursing Facility Services shown above: Maximum of one hundred twenty (120) Inpatient days per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment for Alcohol or Drug Abuse and Dependency.			

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
ALCOHOL OR DRUG ABUSE AND DEPENDENCY TREATMENT (including Detoxification)			
Inpatient *	$600 per day, up to maximum $3,000 per admission	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible
Outpatient			
Office Visit	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
All Other	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Telebehavioral Health	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
AUTISM SPECTRUM DISORDERS	For services that are prescribed for Autism Spectrum Disorders, the cost-sharing will be the lesser of the applicable Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the medical service cost-share.		
Note for Autism Spectrum Disorders shown above: Visit limits do not apply to services provided for this condition.			
BLOOD	20% of Allowed Amount	20% of Allowed Amount **Not** Subject to Deductible	20% of Allowed Amount **Not** Subject to Deductible
Note for Blood shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
HOSPICE SERVICES			
Inpatient Hospice Services	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Outpatient Hospice Services			
Professional Service	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Facility Service for Respite Care	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Note for Hospice Services shown above: Respite Care is provided for a maximum of seven (7) days every six (6) months. Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES			
Artificial Insemination	$90 per Provider, per date of service	$140 per Provider, per date of service **Not** Subject to Deductible	$150 per Provider, per date of service **Not** Subject to Deductible
Maternity/Obstetrical Care			
Professional Service	$90, first visit only	$140, first visit only **Not** Subject to Deductible	$150, first visit only **Not** Subject to Deductible
Facility Services-Inpatient/Birthing Center*	$600 per day, up to maximum $3,000 per admission	$900 per day, up to maximum $4,500 per admission Subject to Deductible	$1,300 per day, up to maximum $6,500 per admission Subject to Deductible
Abortion Services			
Professional Service	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Outpatient Facility Services			
Ambulatory Surgical Facility	$350 per procedure	$350 per procedure **Not** Subject to Deductible	$350 per procedure **Not** Subject to Deductible
Outpatient Hospital-Based Facility	$350 per procedure	$350 per procedure **Not** Subject to Deductible	$350 per procedure **Not** Subject to Deductible
Newborn Care	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
MENTAL HEALTH CARE AND SERIOUS MENTAL ILLNESS HEALTH CARE			
Inpatient *	$600 per day, up to maximum $3,000 per admission	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible
Outpatient			
Office Visit	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
All Other	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Telebehavioral Health	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
METHADONE TREATMENT	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
SURGICAL SERVICES			
Inpatient Professional Services	0%	5% of Allowed Amount, after Deductible	10% of Allowed Amount, after Deductible
Note for Inpatient Professional Services shown above: Cost-sharing does not apply to physician/surgeon fees (including Inpatient Anesthesia) that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Outpatient Facility Charges			
Ambulatory Surgical Facility	$350 per day	$950 per day Subject to Deductible	$1,500 per day Subject to Deductible
Outpatient Hospital-Based Facility	$350 per day	$950 per day Subject to Deductible	$1,500 per day Subject to Deductible
Outpatient Anesthesia	$5 per Provider, per date of service	$5 per Provider, per date of service **Not** Subject to Deductible	$5 per Provider, per date of service **Not** Subject to Deductible
Note for Outpatient Anesthesia shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Voluntary Second Surgical Opinion			
Office Visits	$90 per opinion	$140 per opinion **Not** Subject to Deductible	$150 per opinion **Not** Subject to Deductible
Telemedicine Visits	$65 per opinion	$100 per opinion **Not** Subject to Deductible	$105 per opinion **Not** Subject to Deductible
Note for Surgical Services shown above: 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. Cost-sharing does not apply to Outpatient Surgery services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
TRANSPLANT SERVICES			
Inpatient Transplant Services	$600 per day, up to maximum $3,000 per admission	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible
Outpatient Transplant Services	$350 per procedure	$350 per procedure **Not** Subject to Deductible	$350 per procedure **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
AMBULANCE SERVICES/TRANSPORT			
Emergency	$200 per destination	$200 per destination **Not** Subject to Deductible	$200 per destination **Not** Subject to Deductible
Non-Emergency	$250 per destination	$250 per destination **Not** Subject to Deductible	$250 per destination **Not** Subject to Deductible
DAY REHABILITATION PROGRAM			
Outpatient Visits	20% of Allowed Amount	20% of Allowed Amount **Not** Subject to Deductible	20% of Allowed Amount **Not** Subject to Deductible
Note for Day Rehabilitation Program shown above: Thirty (30) visits per Benefit Period. Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
DENTAL, ACCIDENTAL INJURY	20% of Allowed Amount	20% of Allowed Amount **Not** Subject to Deductible	20% of Allowed Amount **Not** Subject to Deductible
DIABETIC EDUCATION PROGRAM	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
DIABETIC EQUIPMENT AND SUPPLIES	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible
DIAGNOSTIC SERVICES			
Routine Radiology/Diagnostic Services (includes Allergy Testing)			
Freestanding	$150 per date of service	$150 per date of service **Not** Subject to Deductible	$150 per date of service **Not** Subject to Deductible
Hospital-Based	$150 per date of service	$150 per date of service **Not** Subject to Deductible	$150 per date of service **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
Non-Routine Diagnostic Services (including MRI/MRA, CT/CTA scans, PET scans)			
Freestanding	$375 per date of service	$375 per date of service **Not** Subject to Deductible	$375 per date of service **Not** Subject to Deductible
Hospital-Based	$375 per date of service	$375 per date of service **Not** Subject to Deductible	$375 per date of service **Not** Subject to Deductible
Sleep Studies			
Home and Freestanding Facility	$350 per date of service	$950 per date of service **Not** Subject to Deductible	$1,500 per date of service **Not** Subject to Deductible
Outpatient Hospital-Based Facility	$350 per date of service	$950 per date of service **Not** Subject to Deductible	$1,500 per date of service **Not** Subject to Deductible
DURABLE MEDICAL EQUIPMENT AND CONSUMABLE MEDICAL SUPPLIES (including PROSTHETIC DEVICES and ORTHOTICS)	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible
Note for Durable Medical Equipment and Consumable Medical Supplies shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
EMERGENCY SERVICES – Facility	$950 per service/ occurrence (waived if admitted)	$950 per service/ occurrence (waived if admitted) **Not** Subject to Deductible	$950 per service/ occurrence (waived if admitted) **Not** Subject to Deductible
Note for Emergency Services shown above: The emergency room cost share will be the PCP office visit cost share 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. Non-Participating Providers for Emergency and Out-of-Area Urgent Care Services, to the extent the Urgent Care services are Emergency services, will be reimbursed pursuant to the methodology established by the Consolidated Appropriations Act (CAA). The Member will be subject to the in-network cost-sharing levels.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
HABILITATIVE SERVICES			
Physical Therapy/Occupational Therapy			
Freestanding	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Hospital-Based	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Physical Therapy/Occupational Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. There is no visit limit for lymphedema therapy related to a mastectomy. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Physical Therapy/Occupational Therapy cost-share.			
Speech Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Speech Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Speech Therapy cost-share.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
HOME HEALTH CARE	$0	$200 per Provider, per date of service **Not** Subject to Deductible	$250 per Provider, per date of service **Not** Subject to Deductible
Note for Home Health Care shown above: Maximum of Sixty (60) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. Special or Private Duty Nursing Not Included. *Note for Home Health Care shown above:* Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
INJECTABLE MEDICATIONS			
Standard Injectable Drugs (includes Allergy Injections)	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Biotech/Specialty Drugs			
Home/Office	50% of the Allowed Amount	50% of the Allowed Amount **Not** Subject to Deductible	50% of the Allowed Amount **Not** Subject to Deductible
Outpatient	50% of the Allowed Amount	50% of the Allowed Amount **Not** Subject to Deductible	50% of the Allowed Amount **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
Note for Injectable Medications shown above: The cost-sharing amounts for injected or infused drugs set forth above are applicable to those injected or infused drugs administered to a Member who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member's Deductible, if applicable, or Out-of-Pocket Maximum. Additionally, the HMO may elect to implement a program whereby each separate injected or infused drug will be paid by the HMO subject to variable copayment amounts. This variable copayment amount associated with an injected or infused drug or for certain other high-cost injected or infused drugs experienced by a Member will not result in a Member paying more cost-sharing out of pocket for an injected or infused drug than they would have paid absent the HMO's application of the program. Members who exhaust cost-sharing assistance available from a manufacturer will not be responsible for more cost-sharing for the drug or refill than the amount for which they were responsible while receiving such cost-sharing assistance. Cost-sharing does not apply to Biotech/Specialty Drugs that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
LABORATORY AND PATHOLOGY TESTS			
LabCorp and Independent Labs	$25 per date of service	$25 per date of service **Not** Subject to Deductible	$25 per date of service **Not** Subject to Deductible
Hospital-Based	$25 per date of service	$25 per date of service **Not** Subject to Deductible	$25 per date of service **Not** Subject to Deductible
MEDICAL CARE			
Outpatient Professional Services	$5 per Provider, per date of service	$15 per Provider, per date of service, after Deductible	$25 per Provider, per date of service, after Deductible
Note for Medical Care shown above: Cost-sharing does not apply to physician/surgeon fees (Medical Care) that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
MEDICAL FOODS AND NUTRITIONAL FORMULAS	20% of the Allowed Amount	20% of the Allowed Amount **Not** Subject to Deductible	20% of the Allowed Amount **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
REHABILITATIVE SERVICES			
Physical Therapy/Occupational Therapy			
Freestanding	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Hospital-Based	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Physical Therapy/Occupational Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. There is no visit limit for lymphedema therapy related to a mastectomy. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Physical Therapy/Occupational Therapy cost-share.			
Speech Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Speech Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Speech Therapy cost-share.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
SPINAL MANIPULATION SERVICES	$50 per Provider, per date of service	$50 per Provider, per date of service **Not** Subject to Deductible	$50 per Provider, per date of service **Not** Subject to Deductible
Note for Spinal Manipulation Services shown above: Twenty (20) visits per Benefit Period. *For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Spinal Manipulation Services cost-share.*			
THERAPY SERVICES			
Cardiac Rehabilitation Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Cardiac Rehabilitation Therapy shown above: Thirty-six (36) visits per Benefit Period. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Cardiac Rehabilitation Therapy cost-share.			
Chemotherapy	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Chemotherapy shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Dialysis	$30 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$150 per Provider, per date of service **Not** Subject to Deductible
Note for Dialysis shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
Infusion Therapy			
Home/Office	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Outpatient	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Infusion Therapy shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Pulmonary Rehabilitation Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Pulmonary Rehabilitation Therapy shown above: Thirty-six (36) visits per Benefit Period. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Pulmonary Rehabilitation Therapy cost-share.			
Radiation Therapy	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Radiation Therapy shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Respiratory Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Respiratory Therapy shown above: For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Respiratory Therapy cost-share.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
URGENT CARE CENTER - Facility	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible

BENEFIT	**FOR BENEFITS PROVIDED BY CONTRACTED VENDORS:**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
VIRTUAL CARE SERVICES (Vendor/Virtual Provider)			
Telemedicine Visit	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Teledermatology	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Telebehavioral Health	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

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)**
PRESCRIPTION DRUG DEDUCTIBLE: Deductible must be met before applicable Coinsurance amounts are applied, unless noted otherwise below. The Prescription Drug Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Prescription Drug Deductible for that Benefit Period, or the Prescription Drug Family Deductible has been satisfied for all covered family members combined.	
Per Individual	$225
Per Family	$450
Participating Retail Pharmacy**	
Low-Cost Generic Drugs	$7 Prescription Drug Deductible does not apply
Generic Drugs	$25 Prescription Drug Deductible does not apply
Preferred Brand Drugs	$100 after Prescription Drug Deductible
Non-Preferred Drugs	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $500
Specialty Drugs***	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $1,000

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:	
Low-Cost Generic Drugs	$7 Prescription Drug Deductible does not apply
Generic Drugs	$25 Prescription Drug Deductible does not apply
Preferred Brand Drugs	$100 after Prescription Drug Deductible
Non-Preferred Drugs	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $500
For a 31-90 days-supply:	
Low-Cost Generic Drugs	$17.50 Prescription Drug Deductible does not apply
Generic Drugs	$62.50 Prescription Drug Deductible does not apply
Preferred Brand Drugs	$250 after Prescription Drug Deductible
Non-Preferred Drugs	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $1,250

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (Continued)	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Non-Participating Pharmacy	Member pays 70% of Allowed Amount for Covered Drugs or Supplies. after Prescription Drug Deductible* *Prescription Drug Deductible does not apply to Generic Drugs.

**The pharmacy benefits manager's (PBM's) preferred Retail Pharmacy network is a subset of the national retail pharmacy network and includes most major chains and local pharmacies. To verify that a Retail Pharmacy is participating in the preferred Retail Pharmacy network, call the Customer Service telephone number shown on the Member's Identification Card. Out-of-Network benefits apply to prescriptions filled at non-preferred Retail Pharmacies and the Member will pay the full retail price for their prescription then file a paper claim for reimbursement.

******* The cost-sharing amounts for a specialty drug prescription or for certain other high-cost Prescription Drugs set forth above are applicable to those Prescription Drugs dispensed to a Member who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member's Program Deductible or Out-of-Pocket Limit. Additionally, the HMO may elect to implement a program whereby each separate Prescription Order or refill for the Prescription Drug will be paid by the HMO subject to the Member's Coinsurance of 30%. This 30% Coinsurance associated with a Specialty Drug Prescription or for certain other high-cost Prescription Drugs experienced by a Member will not result in a Member paying more cost-sharing out-of-pocket for a Prescription Drug or refill than they would have paid absent the HMO's application of the program. Members who exhaust cost-sharing assistance available from a manufacturer will not be responsible for more cost-sharing for the Prescription Drug or refill than the amount for which they were responsible while receiving such cost-sharing assistance.

†† 31-90 day supplies of Prescription Drugs to treat chronic conditions are available at the Participating Mail Service Pharmacy and a designated retail pharmacy.

PRESCRIPTION DRUG LIMITATIONS

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

1. Not covered are drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy.
2. A pharmacy need not dispense a Prescription Order which, in the Pharmacist's professional judgment, should not be filled, without first consulting with the prescribing Physician.
3. The quantity of a 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 or a designated retail pharmacy for the Prescription Drug cost sharing as shown on this Schedule**.**
4. Members must present their Identification Card, and the existence of Prescription Drug coverage must be indicated on the card.

PRESCRIPTION DRUG LIMITATIONS (Continued)

5. 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 their Identification Card; or

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

   C. The applicable Prescription Drug cost sharing.

6. 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.

7. 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.

8. The dollar amount paid by a third party will not accumulate toward any applicable Deductible or Out-of-Pocket Maximum to the extent permitted by law.

***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 certain generic products and brand products. All other 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***
* Annual Deductible does not apply to Pediatric Vision benefits	
VISION CARE	
Participating Provider	
Routine Eye Exam & Refraction	$0 Deductible does not apply Once every Benefit Period
Frames and Prescription Lenses	$0 Deductible does not apply Once every Benefit Period
Elective Contact Lenses (in lieu of eyeglasses), including Standard, Specialty and Disposable Lenses	
Davis Collection	$0 Deductible does not apply
Non-Collection	$0, up to a maximum of $150 Allowance and a 15% discount off balance over the $150 maximum, not available at all Participating Providers Deductible does not apply
Elective Contact Lenses Fitting and Follow-up Care	
Standard Lenses	$0 Deductible does not apply
Specialty and Disposable Lenses	$0, up to a maximum of $60 Allowance and a 15% discount off balance over the $60 maximum, not available at all Participating Providers Deductible does not apply
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses	$0 Deductible does not apply
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
Other Diagnostic & Preventive Services	Not Covered
Teledentistry, synchronous or asynchronous	0% Dental deductible does not apply
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% Dental deductible does not apply

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. Teledentistry – must be accompanied by a covered procedure.
8. Space maintainers – one (1) per five (5) year period for Members 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.
9. Sealants – one (1) per tooth per 36 months.
10. Preventive resin restorations – one (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.
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.

PEDIATRIC DENTAL LIMITATIONS: (Continued)

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 anterior teeth, primary posterior teeth, incisor teeth, primary molars and cuspids up to age 11.
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). Limited to 30 minutes, per session when Dentally Necessary and related to Covered Services.
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:

- Services, supplies or charges which are:
  - Not provided by or Referred by the Member's Primary Care Physician except in an Emergency; or as specified elsewhere in this Agreement;
  - 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
  - Provided by family members, relatives and friends;

- 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;

- 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;

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

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

- 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;

- 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;

- 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:
    - For dental implants for any reason;
    - For dentures, unless for the initial treatment of an Accidental Injury or trauma;
    - For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
    - For oral devices used for temporomandibular joint syndrome or dysfunction;
    - For injury as a result of chewing or biting (neither is considered an Accidental Injury);

- 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;

- 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:
  - The investigational item, device, or service, itself;
  - 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
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

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

- For care in a:
  - Long-term care facility, including a:
    - Nursing home;
    - Assisted living facility; and
    - Board and care home;
  - Continuing care retirement facility;
  - Convalescent home;

- School, with the exception of behavioral health services specified in the HMO's Medical Policies;
- Camp, with the exception of behavioral health services specified in the HMO's Medical Policies; or
- Institution for intellectually disabled children;

- 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;

- Any Therapy Service provided for:
  - Work hardening activities/programs;
  - Evaluations not associated with therapy;

- Vision care including, but not limited to:
  - 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;
  - For Members age nineteen (19), 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
  - Lenses which do not require a Prescription;
  - Mirror coatings;
  - Deluxe frames; or
  - Eyeglass accessories such as cases, cleaning solution and equipment;

- Immunizations required for employment purposes or travel.

- Custodial and Domiciliary Care; protective and supportive care, including educational services, rest cures and convalescent care;

- Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary.

  This exclusion also applies to pharmacological drugs for the treatment of obesity including coverage for other FDA approved indications when the benefit to the condition is due to weight loss or the reliable evidence does not establish clinical effectiveness independent of weight loss.

  This exclusion does not apply to the HMO's weight reduction program or nutrition counseling visits/sessions as described in the Nutrition Counseling provision in this Agreement;

- For appetite suppressants;
- For oral non-elemental nutritional supplements, hydrolyzed formulas, 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;
- For elemental semi-solid foods;
- For products that replace fluids and electrolytes;
- For additives to enteral formula and food thickeners;
- For supplies associated with the oral administration of formula (e.g. bottles, nipples);
- Customized wheelchairs;
- 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;
- 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;
- Marriage or religious counseling;
- Reversal of voluntary sterilization and services required in connection with such procedures;
- Ambulance Services/Transport, unless Medically Necessary and as provided in the subsection entitled "Ambulance Services/Transport" specified in Section CS – Description of Covered Services of this Agreement;
- 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;
- Charges for completion of any insurance form;
- For Prescription Drugs and medications, except as provided under the Prescription Drug Benefit described in this Agreement;
- For Contraceptives, except as covered under the Prescription Drug Benefit described in this Agreement;
- Medication furnished by any other medical service for which no charge is made to the Member;
- 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;
- 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:
  - Rehabilitation Therapy Services (other than Speech Therapy and services for Autism Spectrum Disorders);

- Diagnostic radiology services for Members age five (5) or older; and
- Laboratory and pathology tests;

- 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);

- Inpatient or Outpatient Care Private Duty Nursing services;

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

- 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.

- 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;

- Services Incurred prior to the Effective Date of Coverage;

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

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

- Charges not billed and performed by a Provider;

- 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;

- For treatment of obesity, including for surgical treatment of obesity and pharmacological drugs for the treatment of obesity management. This includes, but is not limited to:
  - Weight management programs;
  - Dietary aids, supplements;
  - Weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician;
  - Group nutrition counseling.

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

- Charges in excess of benefit maximums;

- 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;

- For sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed Sex Therapist;

- With regard to Durable Medical Equipment (DME), items for which any of the following statements are true is not DME and will not be covered. Any item:
  - 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.
  - 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.
  - 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:
    - Is not durable; or
    - Is not a component of the DME.
  - 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: exercise equipment; speech teaching machines; strollers; toileting systems; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.
  - 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.
  - 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.
  - 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.
  - That modifies vehicles, dwellings, and other structures. This includes:
    - Any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability; or
    - Any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
  - 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.
  - 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.

- With regard to Consumable Medical Supplies, any item that meets the following criteria is not a covered consumable medical supply and will not be covered:
  - The item is for comfort or convenience.
  - The item is not primarily medical in nature. Items not covered include, but are not limited to:
    - Ear plugs;
    - Ice pack;
    - Silverware/utensils;
    - Feeding chairs;
    - Toilet seats.
  - The item has features of a medical nature which are not required by the patient's condition.
  - The item is generally not prescribed by an eligible provider.

  Some examples of not covered consumable medical supplies are:
  - Incontinence pads;
  - Lamb's wool pads;
  - Face masks (surgical);
  - Disposable gloves, sheets and bags, bandages, antiseptics, and skin preparations;

- For Skilled Nursing Facility benefits:
  - 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;
  - For the treatment of Alcohol Or Drug Abuse And Dependency and Mental Illness Health Care; or
  - After the Member has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care;

- For Hospice Care benefits for the following:
  - Private Duty Nursing care;
  - Research studies directed to life lengthening methods of treatment;
  - 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
  - Treatment to cure the Member's illness;

- With regard to Home Health Care services and supplies in connection with home health services for the following:
  - Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
  - Rental or purchase of Durable Medical Equipment;
  - 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;
  - Prescription Drugs;
  - Provided by family members, relatives, and friends;
  - A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
  - Emergency or non-emergency ambulance services;
  - Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
  - Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and

- 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;

- For home blood pressure machines, except for Members:
  - With pregnancy-induced hypertension;
  - With hypertension complicated by pregnancy;
  - With end-stage renal disease receiving home Dialysis; or
  - Who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates;

- 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;

- Hearing or audiometric examinations, and Hearing Aids, and the fitting thereof. and, routine hearing examinations; Services and supplies related to these items are not covered. Cochlear electromagnetic hearing devices, a semi-implantable hearing aid, is not covered. Cochlear electromagnetic hearing devices are not considered cochlear implants;

- 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;

- Wigs and other items intended to replace hair loss due to androgenetic alopecia; or due to illness or injury including but not limited to injury due to traumatic or surgical scalp avulsion, burns, or Chemotherapy;

- 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;

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

- 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;

- 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;

- For health foods, dietary supplements, or diet agents;

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

- Charges for Orthoptic/Pleoptic Therapy;

- Coverage is not provided for the services or treatment related to an Elective Abortion, an abortion that is the voluntary termination of pregnancy other than one which is necessary to prevent the death of the woman, or to terminate a pregnancy that was caused by rape or incest;

- The following Exclusions apply to your Prescription Drug benefits:
  - Drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy;
  - 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:
    - Devices used for the treatment or Maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and
    - Devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines; or
    - Contraceptive devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordable Care Act;
  - Drugs Prescribed and administered in the Physician's office;
  - 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 certain drugs that are specifically designated by the HMO, whether or not Prescribed by a Physician;
  - Any drugs covered under another provision of the Agreement;
  - Prescription Drugs covered without charge under federal, state or local programs including Worker's Compensation and Occupational Disease laws;
  - Medication for a Member confined to a rest home, Skilled Nursing Facility, sanitarium, extended care facility, Hospital or similar entity;
  - Medication furnished by any other medical service for which no charge is made to the Member;
  - Any Covered Drug or Supply administered at the time and place of the Prescription Order;
  - Any charges for the administration of Prescription Legend Drugs or injectable insulin;
  - Prescription Drugs provided by Non-Participating Pharmacies, except as specified in Section RX-Prescription Drug Benefits;

- Prescription Refills resulting from loss or theft, or any unauthorized Refills;
- Immunization agents (except those covered on the Drug Formulary), biological sera, blood or plasma, or allergy serum;
- Experimental or Investigational Drugs or drugs Prescribed for experimental (non-FDA approved) indications;
- 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;
- Injectables used for treatment of infertility when they are prescribed solely to enhance or facilitate conception;
- 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;
- Specialty Drugs that are not purchased through a pharmacy other than those specified in Section RX – Prescription Drug Benefits. This exclusion does not apply to Insulin;
- Any charge where the usual and customary charge is less than the Member's cost-sharing amount;
- For Convenience Pack drugs which combine two or more individual drug products into a single package with a unique national drug code;

- 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:**

  - Incurred prior to the Subscriber's Effective Date of Coverage or after the Termination Date of coverage under the Individual Agreement.
  - For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
  - For prescription and non-prescription drugs, vitamins or dietary supplements.
  - 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).
  - Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
  - 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.
  - 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.
  - For treatment of fractures and dislocations of the jaw.
  - For treatment of malignancies or neoplasms.
  - 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.
  - For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
  - For periodontal splinting of teeth by any method.
  - For duplicate dentures, Prosthetic Devices or any other duplicative device.
  - For which in the absence of insurance the Member would Incur no charge.
  - For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
  - For treatment and appliances for bruxism (night grinding of teeth).
  - 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.

- 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).
- 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.
- For specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).
- Fees for broken appointments.
- 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.
- 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 in 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;

- For laboratory and pathology tests in connection with obtaining or continuing employment;

- Liposuction (suction-assisted lipectomy) for the treatment of lipedema;
  This exclusion does not apply to:

  - Liposuction (suction-assisted lipectomy) for the treatment of lipedema when the HMO:
    - Determines the liposuction (suction-assisted lipectomy) is Medically Necessary; and
    - The liposuction (suction-assisted lipectomy) is limited to one procedure per area of the body per lifetime;

- For services designated as intensive behavioral health services/pediatric intensive behavioral health services (defined in Pennsylvania Medical Assistance Manual Chapter 1155), except as specifically provided under this Program (For example, Home Health Care);

- Drugs, Biologics, and Gene Therapies That Have Not Received Final/Standard/Traditional FDA Approval.

  For drugs, biologics, or gene therapies, **with the exception of cancer treatments,** that receive an accelerated approval based on surrogate endpoints with the requirement by the FDA to perform confirmatory trials to demonstrate clinical benefits **and not** of a final, standard, traditional FDA approval **for a period of 18 months after the accelerated approval.**

  Monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease: e.g., aducanumab- avwa

  Delandistrogene moxeparvovec

Tofersen

Exon skipping drugs for Duchenne Muscular Dystrophy (DMD): e.g., Eteplirsen, Golodirsen, Viltolarsen, Casimersen

Lecanemab-irmb (Leqembi)

- With regard to the Autism benefit, the following exclusions apply:
  - For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
  - For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

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, Coinsurance and/or Deductibles.

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.

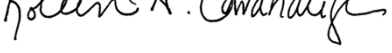
GUARANTEED RENEWABLE: Upon the payment of the applicable rate, the HMO agrees to make payment for those services as set forth in this Subscriber Agreement. Subject to the right of the HMO to terminate coverage in accordance with **Section EL – Eligibility, Change And Termination Rules Under The Plan**, 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.

ATTEST:



Koleen Cavanaugh
SVP and Chief Marketing Officer



Jonathan Stump
VP Product Services

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-2583 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 3852-572-008-1 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-800-275-2583 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

普通话: 注意：如果您说普通话，我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务，确保以无障碍格式传递信息。请致电 1-800-275-2583（TTY：711）或咨询服务提供者。

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-2583 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ़्त में उपलब्ध हैं। सुलभ फ़ॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ़्त में मिलती हैं। 1-800-275-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-275-2583 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

한국어를: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-800-275-2583 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjį' bee adahodooníłí diné bich'į' anídahazt'i'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'i'go hadadilyaaígíí ałdó' t'áá jiik'eh hǫlǫ́. Kohjį' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'į' hanidziih.

Pennsilfaanisch-Deitsch: WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాష సహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్‌కు కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÍ: Tí o bá nsọ Yorùbá, àwọn iṣẹ́ àtilẹhin èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtilẹhìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna irááyèsi kíka wà lárọwọ́tó bakanna lọ́fẹ̀ẹ́. Pe 1-800-275-2583 (TTY: 711) tàbi ki ó bá olùpèsè rẹ sọ̀rọ̀.

Discrimination Is Against the Law

This plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This plan does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator.

If you believe that this Plan 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: **civilrightscoordinator@1901market.com**.

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available at the following website: **www.healthinsurancehosting.com/notices**.

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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 SC - SCHEDULE OF COST SHARING & LIMITATIONS

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

If the Participating Provider's usual fee for a Covered Service is less than the cost sharing amount shown in this Schedule, you are only responsible to pay the Participating Provider's usual fee. The Participating Provider is required to remit any cost sharing overpayment amount 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.

This plan has a Tiered Network. For the purpose of this Program, each benefit tier (shown in the columns below) refers to your cost share based on the tier level of the Participating Provider you receive services from. Providers included in each tier (Preferred, Enhanced, or Standard) are part of a selected subset of the HMO's entire network of Participating Providers. **Section MC – Using the HMO System** provides more detail regarding Provider Tiers. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider.

Non-Participating Providers for Emergency and Out-of-Area Urgent Care Services, to the extent the Urgent Care services are Emergency services, will be reimbursed pursuant to the methodology established by the Consolidated Appropriations Act (CAA). The Member will be subject to the in-network cost-sharing levels.

To find a list of Participating Providers with their designations, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

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

	TIER 1 PREFERRED	TIER 2 ENHANCED	TIER 3 STANDARD
ANNUAL DEDUCTIBLE			
Per Member	$0	$6,000 applicable to Tiers 2 and 3	
Per Family	$0	$12,000 applicable to Tiers 2 and 3	
The Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Deductible for that Benefit Period, or the Family Deductible has been satisfied for all covered family Members combined. The Deductible under this tiered plan is an aggregate of any Deductibles paid under all Tiers for which a Deductible applies. For example, any Deductibles paid when the Member receives services from Tier 2 and Tier 3 Providers are combined to apply toward the Annual Deductible listed above.			
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
OUT-OF-POCKET MAXIMUM			
Per Member	$10,500		
Per Family	$21,000		
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 Coinsurance, Copayment and/or Deductible amounts, if applicable, 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. Amounts paid for Covered Services received under Tiers 1, 2 and 3 will be applied and accumulate concurrently towards the Out-of-Pocket maximum.			
COINSURANCE PERCENTAGE	0%	5% of the Allowed Amount	10% of the Allowed Amount
Coinsurance is applied to some of the Covered Services listed below, but not to Covered Services that require the Member to pay a Copayment amount. Coinsurance is a percentage of the Covered Service that must be paid by the Member; it is applied after the Deductible is met in each Benefit Period. A Deductible may also apply to certain services that are subject to a Copayment. Those services that are subject to a Deductible with a Copayment are identified below. The Member will also be responsible to pay costs for services that are not covered by the HMO plan.			
LIFETIME BENEFIT MAXIMUM	Unlimited		

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
OFFICE VISITS/TELEMEDICINE VISITS TO YOUR PCP (Non-Preventive)			
Office Visits (Includes Retail Clinic Visits, Home Visits and Outpatient Consultations)	$40 per Provider, per date of service	$70 per Provider, per date of service **Not** Subject to Deductible	$80 per Provider, per date of service **Not** Subject to Deductible
Telemedicine Visits (excluding Retail Clinics)	$30 per Provider, per date of service	$50 per Provider, per date of service **Not** Subject to Deductible	$55 per Provider, per date of service **Not** Subject to Deductible
Note for Office Visits/Telemedicine Visits to your PCP shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.			
OFFICE VISITS/TELEMEDICINE VISITS TO A SPECIALIST			
Office Visits	$90 per Provider, per date of service	$140 per Provider, per date of service **Not** Subject to Deductible	$150 per Provider, per date of service **Not** Subject to Deductible
Telemedicine Visits	$65 per Provider, per date of service	$100 per Provider, per date of service **Not** Subject to Deductible	$105 per Provider, per date of service **Not** Subject to Deductible
Note for Office Visits/Telemedicine Visits to a Specialist shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.			

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
PEDIATRIC PREVENTIVE CARE	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
IMMUNIZATIONS	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
ADULT PREVENTIVE CARE	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Routine/Preventive Colonoscopy			
Preventive Plus (P+) Facility/Non-Hospital based Facility**	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Non-Preventive Plus (P+) Facility/Hospital based Facility**	$750 per procedure	$750 per procedure **Not** Subject to Deductible	$750 per procedure **Not** Subject to Deductible
Note for Routine/Preventive Colonoscopy shown above: *For $0 Member cost-sharing to apply, all services must be performed by a Participating gastroenterologist or a colon and rectal surgeon. **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. In addition to seeking services from Preventive Plus Providers, colonoscopy screenings must meet the United States Preventive Services Task Force's (USPSTF) guidelines for $0 Member cost sharing to apply.			
WOMEN'S PREVENTIVE HEALTH CARE (Includes Routine Gynecological Exam, Pap Smear, one (1) per Benefit Period, all ages)	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
MAMMOGRAMS	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

PRIMARY AND PREVENTIVE CARE COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
NUTRITION COUNSELING	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Note for Nutrition Counseling shown above: Six (6) Outpatient nutrition counseling visits/sessions per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
SMOKING CESSATION	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
HOSPITAL SERVICES			
Inpatient and Emergency Admissions*	$600 per day, up to maximum $3,000 per admission	$900 per day, up to maximum $4,500 per admission Subject to Deductible	$1,300 per day, up to maximum $6,500 per admission Subject to Deductible

INPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
MEDICAL CARE			
Inpatient Professional Service	0% of the Allowed Amount	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Inpatient Professional Services shown above: Cost-sharing does not apply to physician/surgeon fees (including Inpatient Anesthesia) that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
SKILLED NURSING FACILITY SERVICES*	$300 per day, up to a maximum of 1,500 per admission	$300 per day, up to a maximum of 1,500 per admission **Not** Subject to Deductible	$300 per day, up to a maximum of 1,500 per admission **Not** Subject to Deductible
Note for Skilled Nursing Facility Services shown above: Maximum of one hundred twenty (120) Inpatient days per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment for Alcohol or Drug Abuse and Dependency.			

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
ALCOHOL OR DRUG ABUSE AND DEPENDENCY TREATMENT (including Detoxification)			
Inpatient *	$600 per day, up to maximum $3,000 per admission	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible
Outpatient			
Office Visit	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
All Other	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Telebehavioral Health	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
AUTISM SPECTRUM DISORDERS	For services that are prescribed for Autism Spectrum Disorders, the cost-sharing will be the lesser of the applicable Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the medical service cost-share.		
Note for Autism Spectrum Disorders shown above: Visit limits do not apply to services provided for this condition.			
BLOOD	20% of Allowed Amount	20% of Allowed Amount **Not** Subject to Deductible	20% of Allowed Amount **Not** Subject to Deductible
Note for Blood shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
HOSPICE SERVICES			
Inpatient Hospice Services	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Outpatient Hospice Services			
Professional Service	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Facility Service for Respite Care	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Note for Hospice Services shown above: Respite Care is provided for a maximum of seven (7) days every six (6) months. Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
MATERNITY/OBSTETRICAL – GYNECOLOGICAL/FAMILY SERVICES			
Artificial Insemination	$90 per Provider, per date of service	$140 per Provider, per date of service **Not** Subject to Deductible	$150 per Provider, per date of service **Not** Subject to Deductible
Maternity/Obstetrical Care			
Professional Service	$90, first visit only	$140, first visit only **Not** Subject to Deductible	$150, first visit only **Not** Subject to Deductible
Facility Services-Inpatient/Birthing Center*	$600 per day, up to maximum $3,000 per admission	$900 per day, up to maximum $4,500 per admission Subject to Deductible	$1,300 per day, up to maximum $6,500 per admission Subject to Deductible
Abortion Services			
Professional Service	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Outpatient Facility Services			
Ambulatory Surgical Facility	$350 per procedure	$350 per procedure **Not** Subject to Deductible	$350 per procedure **Not** Subject to Deductible
Outpatient Hospital-Based Facility	$350 per procedure	$350 per procedure **Not** Subject to Deductible	$350 per procedure **Not** Subject to Deductible
Newborn Care	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
MENTAL HEALTH CARE AND SERIOUS MENTAL ILLNESS HEALTH CARE			
Inpatient *	$600 per day, up to maximum $3,000 per admission	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible
Outpatient			
Office Visit	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
All Other	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Telebehavioral Health	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
METHADONE TREATMENT	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
SURGICAL SERVICES			
Inpatient Professional Services	0%	5% of Allowed Amount, after Deductible	10% of Allowed Amount, after Deductible
Note for Inpatient Professional Services shown above: Cost-sharing does not apply to physician/surgeon fees (including Inpatient Anesthesia) that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Outpatient Facility Charges			
Ambulatory Surgical Facility	$350 per day	$950 per day Subject to Deductible	$1,500 per day Subject to Deductible
Outpatient Hospital-Based Facility	$350 per day	$950 per day Subject to Deductible	$1,500 per day Subject to Deductible
Outpatient Anesthesia	$5 per Provider, per date of service	$5 per Provider, per date of service **Not** Subject to Deductible	$5 per Provider, per date of service **Not** Subject to Deductible
Note for Outpatient Anesthesia shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Voluntary Second Surgical Opinion			
Office Visits	$90 per opinion	$140 per opinion **Not** Subject to Deductible	$150 per opinion **Not** Subject to Deductible
Telemedicine Visits	$65 per opinion	$100 per opinion **Not** Subject to Deductible	$105 per opinion **Not** Subject to Deductible
Note for Surgical Services shown above: 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. Cost-sharing does not apply to Outpatient Surgery services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

INPATIENT/OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
TRANSPLANT SERVICES			
Inpatient Transplant Services	$600 per day, up to maximum $3,000 per admission	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible	$600 per day, up to maximum $3,000 per admission **Not** Subject to Deductible
Outpatient Transplant Services	$350 per procedure	$350 per procedure **Not** Subject to Deductible	$350 per procedure **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
AMBULANCE SERVICES/TRANSPORT			
Emergency	$200 per destination	$200 per destination **Not** Subject to Deductible	$200 per destination **Not** Subject to Deductible
Non-Emergency	$250 per destination	$250 per destination **Not** Subject to Deductible	$250 per destination **Not** Subject to Deductible
DAY REHABILITATION PROGRAM			
Outpatient Visits	20% of Allowed Amount	20% of Allowed Amount **Not** Subject to Deductible	20% of Allowed Amount **Not** Subject to Deductible
Note for Day Rehabilitation Program shown above: Thirty (30) visits per Benefit Period. Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
DENTAL, ACCIDENTAL INJURY	20% of Allowed Amount	20% of Allowed Amount **Not** Subject to Deductible	20% of Allowed Amount **Not** Subject to Deductible
DIABETIC EDUCATION PROGRAM	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
DIABETIC EQUIPMENT AND SUPPLIES	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible
DIAGNOSTIC SERVICES			
Routine Radiology/Diagnostic Services (includes Allergy Testing)			
Freestanding	$150 per date of service	$150 per date of service **Not** Subject to Deductible	$150 per date of service **Not** Subject to Deductible
Hospital-Based	$150 per date of service	$150 per date of service **Not** Subject to Deductible	$150 per date of service **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
Non-Routine Diagnostic Services (including MRI/MRA, CT/CTA scans, PET scans)			
Freestanding	$375 per date of service	$375 per date of service **Not** Subject to Deductible	$375 per date of service **Not** Subject to Deductible
Hospital-Based	$375 per date of service	$375 per date of service **Not** Subject to Deductible	$375 per date of service **Not** Subject to Deductible
Sleep Studies			
Home and Freestanding Facility	$350 per date of service	$950 per date of service **Not** Subject to Deductible	$1,500 per date of service **Not** Subject to Deductible
Outpatient Hospital-Based Facility	$350 per date of service	$950 per date of service **Not** Subject to Deductible	$1,500 per date of service **Not** Subject to Deductible
DURABLE MEDICAL EQUIPMENT AND CONSUMABLE MEDICAL SUPPLIES (including PROSTHETIC DEVICES and ORTHOTICS)	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider **Not** Subject to Deductible
Note for Durable Medical Equipment and Consumable Medical Supplies shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
EMERGENCY SERVICES – Facility	$950 per service/ occurrence (waived if admitted)	$950 per service/ occurrence (waived if admitted) **Not** Subject to Deductible	$950 per service/ occurrence (waived if admitted) **Not** Subject to Deductible
Note for Emergency Services shown above: The emergency room cost share will be the PCP office visit cost share 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. Non-Participating Providers for Emergency and Out-of-Area Urgent Care Services, to the extent the Urgent Care services are Emergency services, will be reimbursed pursuant to the methodology established by the Consolidated Appropriations Act (CAA). The Member will be subject to the in-network cost-sharing levels.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
HABILITATIVE SERVICES			
Physical Therapy/Occupational Therapy			
Freestanding	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Hospital-Based	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Physical Therapy/Occupational Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. There is no visit limit for lymphedema therapy related to a mastectomy. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Physical Therapy/Occupational Therapy cost-share.			
Speech Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Speech Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Speech Therapy cost-share.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
HOME HEALTH CARE	$0	$200 per Provider, per date of service **Not** Subject to Deductible	$250 per Provider, per date of service **Not** Subject to Deductible
Note for Home Health Care shown above: Maximum of Sixty (60) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. Special or Private Duty Nursing Not Included. *Note for Home Health Care shown above:* Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
INJECTABLE MEDICATIONS			
Standard Injectable Drugs (includes Allergy Injections)	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Biotech/Specialty Drugs			
Home/Office	50% of the Allowed Amount	50% of the Allowed Amount **Not** Subject to Deductible	50% of the Allowed Amount **Not** Subject to Deductible
Outpatient	50% of the Allowed Amount	50% of the Allowed Amount **Not** Subject to Deductible	50% of the Allowed Amount **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
Note for Injectable Medications shown above: The cost-sharing amounts for injected or infused drugs set forth above are applicable to those injected or infused drugs administered to a Member who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member's Deductible, if applicable, or Out-of-Pocket Maximum. Additionally, the HMO may elect to implement a program whereby each separate injected or infused drug will be paid by the HMO subject to variable copayment amounts. This variable copayment amount associated with an injected or infused drug or for certain other high-cost injected or infused drugs experienced by a Member will not result in a Member paying more cost-sharing out of pocket for an injected or infused drug than they would have paid absent the HMO's application of the program. Members who exhaust cost-sharing assistance available from a manufacturer will not be responsible for more cost-sharing for the drug or refill than the amount for which they were responsible while receiving such cost-sharing assistance. Cost-sharing does not apply to Biotech/Specialty Drugs that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
LABORATORY AND PATHOLOGY TESTS			
LabCorp and Independent Labs	$25 per date of service	$25 per date of service **Not** Subject to Deductible	$25 per date of service **Not** Subject to Deductible
Hospital-Based	$25 per date of service	$25 per date of service **Not** Subject to Deductible	$25 per date of service **Not** Subject to Deductible
MEDICAL CARE			
Outpatient Professional Services	$5 per Provider, per date of service	$15 per Provider, per date of service, after Deductible	$25 per Provider, per date of service, after Deductible
Note for Medical Care shown above: Cost-sharing does not apply to physician/surgeon fees (Medical Care) that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
MEDICAL FOODS AND NUTRITIONAL FORMULAS	20% of the Allowed Amount	20% of the Allowed Amount **Not** Subject to Deductible	20% of the Allowed Amount **Not** Subject to Deductible

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
REHABILITATIVE SERVICES			
Physical Therapy/Occupational Therapy			
Freestanding	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Hospital-Based	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Physical Therapy/Occupational Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. There is no visit limit for lymphedema therapy related to a mastectomy. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Physical Therapy/Occupational Therapy cost-share.			
Speech Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Speech Therapy shown above: Thirty (30) visits per Benefit Period. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Speech Therapy cost-share.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
SPINAL MANIPULATION SERVICES	$50 per Provider, per date of service	$50 per Provider, per date of service **Not** Subject to Deductible	$50 per Provider, per date of service **Not** Subject to Deductible
Note for Spinal Manipulation Services shown above: Twenty (20) visits per Benefit Period. *For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Spinal Manipulation Services cost-share.*			
THERAPY SERVICES			
Cardiac Rehabilitation Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Cardiac Rehabilitation Therapy shown above: Thirty-six (36) visits per Benefit Period. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Cardiac Rehabilitation Therapy cost-share.			
Chemotherapy	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Chemotherapy shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Dialysis	$30 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$150 per Provider, per date of service **Not** Subject to Deductible
Note for Dialysis shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
Infusion Therapy			
Home/Office	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Outpatient	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Infusion Therapy shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Pulmonary Rehabilitation Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Pulmonary Rehabilitation Therapy shown above: Thirty-six (36) visits per Benefit Period. For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Pulmonary Rehabilitation Therapy cost-share.			
Radiation Therapy	0%	5% of the Allowed Amount, after Deductible	10% of the Allowed Amount, after Deductible
Note for Radiation Therapy shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.			
Respiratory Therapy	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible
Note for Respiratory Therapy shown above: For services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, Treatment of Alcohol or Drug Abuse and Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health Care and Serious Mental Illness Health Care Outpatient Office Visit or the Respiratory Therapy cost-share.			

OUTPATIENT COVERED SERVICES COST SHARING & LIMITATIONS (Continued)			
BENEFIT	**COST SHARING/LIMITATIONS**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
URGENT CARE CENTER - Facility	$90 per Provider, per date of service	$90 per Provider, per date of service **Not** Subject to Deductible	$90 per Provider, per date of service **Not** Subject to Deductible

BENEFIT	**FOR BENEFITS PROVIDED BY CONTRACTED VENDORS:**		
	TIER 1 PREFERRED	**TIER 2 ENHANCED**	**TIER 3 STANDARD**
VIRTUAL CARE SERVICES (Vendor/Virtual Provider)			
Telemedicine Visit	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Teledermatology	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible
Telebehavioral Health	$0	$0 **Not** Subject to Deductible	$0 **Not** Subject to Deductible

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)**
PRESCRIPTION DRUG DEDUCTIBLE: Deductible must be met before applicable Coinsurance amounts are applied, unless noted otherwise below. The Prescription Drug Family Deductible will be applied for all family members covered under a Family coverage. It will not be applied to any covered individual family Member once that covered individual has satisfied the Prescription Drug Deductible for that Benefit Period, or the Prescription Drug Family Deductible has been satisfied for all covered family members combined.	
Per Individual	$225
Per Family	$450
Participating Retail Pharmacy**	
Low-Cost Generic Drugs	$7 Prescription Drug Deductible does not apply
Generic Drugs	$25 Prescription Drug Deductible does not apply
Preferred Brand Drugs	$100 after Prescription Drug Deductible
Non-Preferred Drugs	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $500
Specialty Drugs***	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $1,000

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:	
Low-Cost Generic Drugs	$7 Prescription Drug Deductible does not apply
Generic Drugs	$25 Prescription Drug Deductible does not apply
Preferred Brand Drugs	$100 after Prescription Drug Deductible
Non-Preferred Drugs	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $500
For a 31-90 days-supply:	
Low-Cost Generic Drugs	$17.50 Prescription Drug Deductible does not apply
Generic Drugs	$62.50 Prescription Drug Deductible does not apply
Preferred Brand Drugs	$250 after Prescription Drug Deductible
Non-Preferred Drugs	50% for Covered Drugs or Supplies, after Prescription Drug Deductible, up to a Prescription Cost Sharing Maximum (member cost share maximum) of $1,250

PRESCRIPTION DRUG COST SHARING & LIMITATIONS (Continued)	
BENEFIT	**COST SHARING/LIMITATIONS (per 30 day supply)**
Non-Participating Pharmacy	Member pays 70% of Allowed Amount for Covered Drugs or Supplies. after Prescription Drug Deductible* *Prescription Drug Deductible does not apply to Generic Drugs.

**The pharmacy benefits manager's (PBM's) preferred Retail Pharmacy network is a subset of the national retail pharmacy network and includes most major chains and local pharmacies. To verify that a Retail Pharmacy is participating in the preferred Retail Pharmacy network, call the Customer Service telephone number shown on the Member's Identification Card. Out-of-Network benefits apply to prescriptions filled at non-preferred Retail Pharmacies and the Member will pay the full retail price for their prescription then file a paper claim for reimbursement.

*** The cost-sharing amounts for a specialty drug prescription or for certain other high-cost Prescription Drugs set forth above are applicable to those Prescription Drugs dispensed to a Member who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member's Program Deductible or Out-of-Pocket Limit. Additionally, the HMO may elect to implement a program whereby each separate Prescription Order or refill for the Prescription Drug will be paid by the HMO subject to the Member's Coinsurance of 30%. This 30% Coinsurance associated with a Specialty Drug Prescription or for certain other high-cost Prescription Drugs experienced by a Member will not result in a Member paying more cost-sharing out-of-pocket for a Prescription Drug or refill than they would have paid absent the HMO's application of the program. Members who exhaust cost-sharing assistance available from a manufacturer will not be responsible for more cost-sharing for the Prescription Drug or refill than the amount for which they were responsible while receiving such cost-sharing assistance.

†† 31-90 day supplies of Prescription Drugs to treat chronic conditions are available at the Participating Mail Service Pharmacy and a designated retail pharmacy.

PRESCRIPTION DRUG LIMITATIONS

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

1. Not covered are drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy.
2. A pharmacy need not dispense a Prescription Order which, in the Pharmacist's professional judgment, should not be filled, without first consulting with the prescribing Physician.
3. The quantity of a 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 or a designated retail pharmacy for the Prescription Drug cost sharing as shown on this Schedule.
4. Members must present their Identification Card, and the existence of Prescription Drug coverage must be indicated on the card.

PRESCRIPTION DRUG LIMITATIONS (Continued)

5. 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 their Identification Card; or

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

   C. The applicable Prescription Drug cost sharing.

6. 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.

7. 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.

8. The dollar amount paid by a third party will not accumulate toward any applicable Deductible or Out-of-Pocket Maximum to the extent permitted by law.

***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 certain generic products and brand products. All other 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***
* Annual Deductible does not apply to Pediatric Vision benefits	
VISION CARE	
Participating Provider	
Routine Eye Exam & Refraction	$0 Deductible does not apply Once every Benefit Period
Frames and Prescription Lenses	$0 Deductible does not apply Once every Benefit Period
Elective Contact Lenses (in lieu of eyeglasses), including Standard, Specialty and Disposable Lenses	
Davis Collection	$0 Deductible does not apply
Non-Collection	$0, up to a maximum of $150 Allowance and a 15% discount off balance over the $150 maximum, not available at all Participating Providers Deductible does not apply
Elective Contact Lenses Fitting and Follow-up Care	
Standard Lenses	$0 Deductible does not apply
Specialty and Disposable Lenses	$0, up to a maximum of $60 Allowance and a 15% discount off balance over the $60 maximum, not available at all Participating Providers Deductible does not apply
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses	$0 Deductible does not apply
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
Other Diagnostic & Preventive Services	Not Covered
Teledentistry, synchronous or asynchronous	0% Dental deductible does not apply
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% Dental deductible does not apply

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. Teledentistry – must be accompanied by a covered procedure.
8. Space maintainers – one (1) per five (5) year period for Members 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.
9. Sealants – one (1) per tooth per 36 months.
10. Preventive resin restorations – one (1) per tooth per lifetime under age sixteen (16) on permanent first and second molars.
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.

PEDIATRIC DENTAL LIMITATIONS: (Continued)

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 anterior teeth, primary posterior teeth, incisor teeth, primary molars and cuspids up to age 11.
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). Limited to 30 minutes, per session when Dentally Necessary and related to Covered Services.
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.

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.

ADVERSE BENEFIT DETERMINATION – A determination that includes any denial, reduction, or rescission of health insurance coverage (when, in connection with the rescission, there is an adverse effect on a particular benefit at that time). An Adverse Benefit Determination may be any of the following:

A. A determination by the Plan or a utilization review entity on its behalf, that based on the information provided and upon application of utilization review, a request for a benefit under a health insurance policy does not meet the Plan's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provide or made, in whole or in part, for the benefit.
B. The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Plan of a Member's eligibility for coverage under a health insurance policy or noncompliance with an administrative policy.
C. A rescission of coverage determination by the Plan.

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 Deductibles, 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 is defined as a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine based on recognition by the National Institutes of Health.

AMBULATORY SURGICAL FACILITY – A facility operated, licensed or approved as an Ambulatory Surgical Facility by the responsible state agency, which provides specialty or multispecialty outpatient surgical treatment or procedure that is not located on the premises of a Hospital.

It is 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.

APPEAL OF AN ADMINISTRATIVE DENIAL – An appeal of any of the following types of Adverse Benefit Determinations:

A. Prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy.
B. Certain surprise medical bills received by a Member from an out-of-network provider.
C. Rescission of coverage (except for failure to pay premiums or coverage contributions) that has not been resolved by the Plan and has been filed with the Pennsylvania Insurance Department.

This term does not include a 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 an Appeal of an Administrative Denial (written or oral).

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.

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

AUTHORIZED GENERICS - Brand Name Drugs that are marketed without the brand name on its label. An authorized generic may be marketed by the brand name drug company, or another company with the brand company's permission. Unlike a standard Generic Drug, the authorized generic is not approved by the Food and Drug Administration (FDA) abbreviated new drug application process (ANDA). For cost sharing purposes authorized generics are treated as Brand Name Drugs.

AUTISM SERVICE PROVIDER - A person, entity or group that provides treatment of Autism Spectrum Disorders (ASD), using an ASD Treatment Plan, and that is either:

A. Licensed or certified in this Commonwealth; or
B. Enrolled in the Commonwealth's medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders law.

An Autism Service Provider shall include a Behavioral Specialist.

AUTISM SPECTRUM DISORDERS (ASD) - Any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or its successor.

AUTISM SPECTRUM DISORDERS TREATMENT PLAN (ASD TREATMENT PLAN) - A plan for the treatment of Autism Spectrum Disorders:

A. Developed by a licensed Physician or licensed Psychologist who is a Participating Professional Provider; and
B. Based on a comprehensive evaluation or reevaluation, performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.

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.

BEHAVIORAL SPECIALIST - An individual with appropriate certification or licensure by the applicable state, who designs, implements or evaluates a behavior modification intervention component of an ASD (Autism Spectrum Disorder) Treatment Plan, through Applied Behavioral Analysis which includes:

A. Skill acquisition and reduction of problematic behavior;
B. Improve function and/or behavior significantly; or
C. Prevent loss of attained skill or function.

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:

A. Is licensed as required in the state where it is situated;
B. Is primarily organized and staffed to provide maternity care; and
C. Is under the supervision of a Physician or a licensed Certified 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 Prescription Drug approved by the U.S. Food and Drug Administration (FDA) through the new drug application (NDA) process and in compliance with applicable state laws and regulations. For purposes of this Program, the term "Brand Name Drug" shall also include Authorized Generics and devices which includes 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.

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.

CONSUMABLE MEDICAL SUPPLY – Non-durable medical supplies that cannot withstand repeated use, are usually disposable, and are generally not useful to a person in the absence of illness or injury.

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.

CONVENIENCE PACKS – A combination of two or more individual drug products into a single package with a unique national drug code. Products included in a convenience pack may include prescription products, over-the-counter products, and/or products not approved by the Food and Drug Administration (FDA).

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. That appear on the Drug Formulary, or where an exception has been granted pursuant to the Formulary Exception Policy;
B. 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;
C. Compounded Prescription Drugs containing at least one Legend Drug or Controlled Substance in an amount requiring a Prescription Drug Order or Refill;
D. Insulin (by Prescription Order only); or
E. 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 their 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.

DEDUCTIBLE - A specified amount of Covered Services that must be paid by a Member before benefits are provided for any remaining Covered Services. This amount does not include Copayments amounts, any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Subscriber Agreement. The deductible under this tiered plan is an aggregate of any deductibles paid under all Tiers for which a deductible applies. For example, any deductibles paid when the Member receives services from Tier 2 and Tier 3 Providers are combined to apply toward the Annual Deductible listed in Section SC – Schedule of Cost Sharing & Limitations.

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 Subscriber Agreement.

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 they have 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 covered Prescription Drugs preferred for use by the HMO. This list shall be subject to periodic review and modification by the HMO. Drugs not listed in the Drug Formulary shall not be covered.

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, including services for Mental Illness, 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 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, or diagnostic test, 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.

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

1. When required the drug, biological product, device, medical treatment or procedure, or diagnostic test must have final approval from the appropriate governmental regulatory bodies (e.g. FDA).
2. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
3. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test leads to measurable improvement in health outcomes (That is, the beneficial effects outweigh any harmful effects).
4. Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test 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.

5. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the previous bullet, is possible in standard conditions of medical practice, outside clinical investigative settings.
6. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure, or diagnostic test 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.

Any approval granted as an interim step in the FDA regulatory process (For example: 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 a drug or biological product (e.g. infusible agent) for another diagnosis, condition, or in a manner that does not align with the FDA approval shall require that one or more of the established reference Compendia identified in the Company's policies recognize the usage as appropriate medical treatment.

FACILITY PROVIDER – An institution or entity licensed 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.

GENE REPLACEMENT THERAPY – The scientific development of a functional copy of a missing, non-functioning, or mutated gene, designed to be infused or injected into the body to restore normal function. Examples of Gene Replacement Therapy include Luxturna® (voretigene neparvovec-rzyl) and Zolgensma® (onasemnogene abeparvovec-xioi).

GENERIC DRUG – Any form of a particular drug which is:

A. Sold by a manufacturer other than the original patent holder;
B. Approved by the Federal Food and Drug Administration as generically equivalent through the FDA abbreviated new drug application (ANDA) process; and
C. In compliance with applicable state laws and regulations.

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 within thirty (30) days before the Guest Membership Benefit period ends 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 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:

A. Certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and
B. Appropriately licensed in the state where it is located.

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

INFORMAL MEMBER COMPLAINT - A dispute or objection regarding coverage, including:
A. Exclusions and non-Covered Services under the Program;
B. Participating or Non-Participating Providers' status;
C. Certain surprise medical bills received by the Member from an out of network provider;
D. Recissions of coverage (except for failure to pay premiums or contributions); or
E. The operations or management policies of the HMO.

This definition does not include:
A. An Appeal of an Administrative Denial or a Medical Necessity Appeal; or
B. Disputes or objections that were resolved by the HMO and did not result in the filing of an Appeal of an Administrative Denial (written or oral).

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 they are 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 Agreement 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 NECESSITY APPEAL – An appeal of an Adverse Benefit Determination that the request for a benefit under a health insurance policy does not meet the Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational. This includes an Adverse Benefit Determination that does any of the following:

A. Disapproves full or partial payment for a requested health care service;
B. Approves the provision of a requested health care service for a lesser scope or duration than requested; or
C. Disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service.

The term does not include an Appeal of an Administrative Denial. 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 Medical Necessity Appeal (written or oral).

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. A Member or their Provider should contact the HMO to determine whether a proposed treatment is considered "emerging technology" and whether the provider is considered an eligible provider to perform the "emerging technology" Covered Service. The HMO maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

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;
C. Not primarily for the convenience of the patient, Physician, or other health care Provider;
D. 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;
E. Furnished in the most appropriate and cost-effective setting (site of care) that is appropriate to the Member's medical needs and condition, based on the Member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service; and
F. The drugs that are not eligible for Medical Necessity coverage are listed in the HMO's Medical

Policies or pharmacy service policies. The list of drugs is subject to change.

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 current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).

For purposes of this Program, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness or Autism Spectrum Disorders. The benefit limits for Mental Illness, Serious Mental Illness, and Autism Spectrum Disorders are separate and not cumulative.

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 and 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. Some Generic Drugs are included in this category and are subject to the Non-Preferred Drug cost-sharing.

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, Coinsurance, and Deductible amounts, when applicable; 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. Amounts paid for Covered Services received under Tiers 1, 2 and 3 will be applied and accumulate concurrently towards the Out-of-Pocket maximum.

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 Deductible and 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 plan has a Tiered Network. Participating Providers under this plan may be part of a selected subset, or tier, of the HMO's entire network of Participating Providers. Providers may be classified as Tier 1 (Preferred), Tier 2 (Enhanced), or Tier 3 (Standard). Each tier provides different levels of In-network benefits based on the tier designation of the Participating Provider you receive services from. Your cost sharing (Copayment, Deductible and/or Coinsurance) will be lower for use of Tier 1 Providers, than for Tier 2 and Tier 3. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider. Section MC – Using the HMO System provides more detail regarding Provider Tiers.

To find a list of Participating Providers with their tier designation, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

A Participating Provider may include, 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. The Member may designate a Participating Obstetrician and Gynecologist as their PCP. For children, the Member may designate a pediatrician as the PCP.

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 their 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 and Gynecologists** – A Participating Provider selected by a Member who provides Covered Services without a Referral. 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. Behavioral Specialists are contracted to provide Covered Services for treatment of Autism Spectrum Disorders 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 in 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 their 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 DRUG – These drugs have been selected for their reported medical effectiveness, safety, and value. These drugs generally do not have generic equivalents.

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:
    1. The Non-Participating Pharmacy's charges for the Covered Drug or Supply; or
    2. 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 Non-Participating Pharmacy Prescription Drug Coinsurance, if any, multiplied by the Prescription Drug Allowed 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:
A. A Prescription Drug; or
B. 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 their 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 with an unrestricted, unsanctioned license, who is licensed, where required, and performing services within the scope of such licensure. Professional Providers include, but are not limited to:

A. Audiologist
B. Autism Service Provider
C. Behavioral Specialist
D. Optometrist
E. Certified Registered Nurse
F. Chiropractor
G. Dentist
H. Independent Clinical Laboratory
I. Licensed Clinical Social Worker (for Mental Health Care and Serious Mental Illness services only)
J. Masters Prepared Therapist
K. Certified Midwife
L. Physical Therapist
M. Physician
N. Physician Assistant
O. Podiatrist
P. Psychologist
Q. Registered Dietitian
R. Speech - language Pathologist; and
S. Teacher of the hearing impaired

PROSTHETIC DEVICE - Devices (except dental Prosthetic Devices), which replace all or part of:
A. An absent body organ including contiguous tissue; or
B. The function of a permanently inoperative or malfunctioning body organ.

PROVIDER - Any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to: a Physician, a group of Physicians, allied health professional, Certified 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 they practice; or is 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:

A. Oral drugs;
B. Self-Injectable Drugs;
C. Inhaled drugs; and
D. 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 International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM): 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 – Either of the following:

A. A Prescription Drug prescribed to a Member with a cost that meets or exceeds the cost of a drug on the specialty tier of Medicare Part D under 42 CFR 423.104(d)(2)(iv) (relating to requirements related to qualified prescription drug coverage) and meets three (3) or more of the following criteria:
   1. The drug requires specialized product handling or administration by the dispensing pharmacy.
   2. The drug requires specialized clinical care, including, but not limited to, frequent dosing adjustments to the Prescription Drug, clinical monitoring or expanded patient service, intensive patient counseling and ongoing clinical support, such as individualized disease or therapy management to support patient outcomes for a Member.
   3. The drug is prescribed for a Member with a rare medical condition, complex or chronic medical condition or life-threatening medical condition.
   4. The Prescription Drug has a limited or exclusive distribution and is not typically stocked or dispensed by a retail pharmacy.
B. A Prescription Drug that is prescribed to a Member and that is listed as a specialty drug on the medical assistance fee-for-service specialty pharmacy drug list.

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.

TIERED NETWORK – The sub-network of Providers, which are part of the HMO's entire network of Participating Providers with whom the HMO has a contractual arrangement. The sub-network classifies Providers into separate groups of Providers, or tiers, in order to provide the Member with the choice of different levels of In-network benefits based on the tier designation of the Participating Provider. Your cost sharing (Copayment, Deductible and/or Coinsurance), which is based on the tier designation of the Provider you receive services from, will be lower for use of Tier 1 Providers, than for Tier 2 and Tier 3. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider. Section MC – Using the HMO System provides more detail regarding Provider Tiers.

To find a list of Participating Providers with their tier designation, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

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**).**

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.

  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.

- **Provider Tiers** - This plan has a Tiered Network. Your cost share may be different based on the tier of the Provider you receive services from. Participating Providers under this plan may be part of a selected subset, or tier, of the HMO's entire network of Participating Providers. Providers may be classified as Tier 1, Tier 2, or Tier 3. This plan offers three different levels of in-network benefits based on the tier designation of the Participating Provider you receive services from. Your cost sharing (Copayment, Deductible and/or Coinsurance) will be lower for use of Tier 1 Providers, than for Tier 2 and Tier 3. In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be important to select a PCP and Specialist who have admitting privileges at the Tier 1 Hospital when Hospitalization becomes necessary.

  For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider.

  Some benefits will be covered at the same In-network level of cost sharing such as Preventive Care, Emergency care, Urgent Care, Ambulance, select Outpatient Therapies, and other specialty areas regardless of Provider tier.

  Your cost share will be based on the Participating Provider tier selected for the following services:

  A. Primary care visits
  B. Specialist visits

C. Inpatient hospital services
D. Outpatient hospital services
E. Outpatient surgery
F. Home health services
G. Dialysis

In addition, the benefit design shall also include different cost sharing based on site of service (i.e. Sleep Studies, Chemotherapy, and Radiation Therapy).

To find a list of Participating Providers with their tier designation, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

- **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 Appeal of an Administrative Denial and Medical Necessity Appeal Processes. 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, as well as the Provider's tier designation. 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 their 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 their 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. A Member or their Provider should contact the HMO to determine whether a proposed treatment is considered "emerging technology" and whether the provider is considered an eligible provider to perform the "emerging technology" Covered Service. The HMO maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

- **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 and Prescription Drugs used in the treatment of Autism Spectrum Disorders, 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 Appeal of an Administrative Denial And Medical Necessity Appeal Processes 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 Physician.

  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 Physician. 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 Physician. 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.
A. Hysterectomy
B. Nasal Surgery procedures
C. 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.

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:

A. Some elective surgeries--settings for inpatient and outpatient procedures (e.g. hysterectomy and sinus Surgery)
B. Inpatient Hospital Services
C. Inpatient rehabilitation care
D. Home Health Care
E. Durable Medical Equipment (DME)
F. 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 their 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
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.

C. This plan has a Tiered Network. Your cost share may be different based on the tier of the Provider you receive services from. Participating Providers under this plan may be part of a selected subset, or tier, of the HMO's entire network of Participating Providers. Providers may be classified as Tier 1, Tier 2, or Tier 3. This plan offers three different levels of in-network benefits based on the tier designation of the Participating Provider you receive services from. Your cost sharing (Copayment, Deductible and/or Coinsurance) will be lower for use of Tier 1 Providers, than for Tier 2 and Tier 3. **In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be important to select a PCP and Specialist who have admitting privileges at the Tier 1 Hospital when Hospitalization becomes necessary.**

   For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider.

   To find a list of Participating Providers with their tier designation, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

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:

A. Your Primary Care Physician will supply an electronic form which indicates the services authorized.
B. Your Referral is valid for ninety (90) days from issue date as long as you are a Member.
C. 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.
D. 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.
E. 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 Appeal of an Administrative Denial, 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 Appeal of an Administrative Denial, 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.ibx.com/login and selecting Account Settings and Member Information.

The change will become effective on the earlier of:
A. 14 days after the request is received (includes weekends); or
B. The first day of the upcoming month.

Exceptions: However, changes will take effect on the first of the current month:
1. When the Member did not make a PCP selection at the time of enrollment, or
2. 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.

The Provider Directory will include the tier designation of Participating Providers, including Primary Care Physicians and Referred Specialists, as well Participating Facilities, including Hospitals.

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 an electronic Referral from your Primary Care Physician for inpatient Hospital services that require Preapproval.

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

During an inpatient hospitalization, Care Management and Coordination is monitoring your Hospital stay to assure that a plan for your discharge is in place. This is to make sure that you have a smooth transition from the Hospital to home, or to another setting such as a Skilled Nursing or Rehabilitation Facility. 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 Medical Necessity Appeal Process.

RECOMMENDED PLAN OF TREATMENT

You agree, when joining the HMO, to receive care according to the recommendations of your Primary Care Physician. You have the right to give your informed consent before the start of any procedure or treatment. You also have the right to refuse any drugs, treatment or other procedure offered to you by the HMO Providers, and to be informed by your Physician of the medical consequences of your refusal of any drugs, treatment, or procedure. The HMO and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. 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 Medical Necessity Appeal Process 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 or cost-sharing 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;
G. Public health emergency; or
H. Similar causes.

MEMBER LIABILITY

Except when certain Coinsurance, Copayments, Deductibles or other Limitations are specified in this Subscriber Agreement or in 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, including services for Mental Illness, 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 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 based upon the methodology established by Consolidated Appropriations Act (CAA).

The Member is protected from surprise billing, cannot be balance billed, and will be subject to the in-network cost-sharing levels for Emergency Care provided by Non-Participating Providers. This includes services the Member may receive after they are in stable condition unless written consent is given and the Member gives up their protections not to be balanced billed for these post-stabilization services.

It is your responsibility to contact the HMO for any bill you receive for 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, they will be asked whether they are inside or outside of the United States.
- The Member decides which provider they 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 their ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of their 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 their 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 their ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of their 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.

Renewal of Guest Membership

The Member must renew their Guest Membership for a spouse or Dependent thirty (30) days before the six months or one-year Guest Membership period ends.

The Member must notify the HMO each time they move in or out of the Keystone Service Area.

The Member must call Customer Service at the telephone number on the back of their ID Card, each time the Guest Member moves in or out of the Keystone Service Area so that the HMO may ensure proper assignment of the Primary Care Physician to enable access to care for the Guest Member.
The Member must notify the HMO whenever the following happens:
– The Guest Member comes home for break or a short period of time; or
– The Guest Member returns to the Host Service Area.

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 their 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 APP – APPEAL OF AN ADMINISTRATIVE DENIAL AND MEDICAL NECESSITY APPEAL PROCESS

GENERAL INFORMATION ABOUT THE APPEAL PROCESSES

The HMO maintains an Appeal of an Administrative Denial process and a Medical Necessity 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 their health plan underwritten by the HMO.

The Appeal of an Administrative Denial process and the Medical Necessity Appeal process focus on different issues and have other differences. **Please refer to the separate sections below entitled The Appeal of an Administrative Denial Process and the Medical Necessity Appeal Process for specific information on each process**.

However, the Appeal of an Administrative Denial process and the Medical Necessity 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 Appeal of an Administrative Denial and the Medical Necessity Appeal processes.

- **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 "Authorized Representative "—to pursue an appeal on your behalf. An Authorized 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.

  To authorize someone to be your Authorized 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 Authorized Representative to appeal on their behalf. Authorized Representative 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 **Member Medical Necessity Appeal Process** section below.) You have the right to withdraw or rescind authorization of an Authorized 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 Authorized 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 Authorized Representative by following the steps outlined below in the descriptions of the **Appeal of an Administrative Denial** and **the Medical Necessity Appeal Processes**. 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 Authorized Representative is entitled to a full and fair review. Specifically, at all appeal levels the Member or Authorized Representative may submit additional written comments, records or other information pertaining to the case to the HMO. The HMO takes into account all information submitted by the Member, whether such information was submitted or considered during the initial Adverse Benefit Determination or prior level of review. The HMO documents when the Member fails to submit relevant information by the specified deadline. The Member or Authorized Representative may specify the remedy or corrective action being sought. At the Member's or Authorized Representative's request, the HMO will provide access to and copies of all relevant documents, records, and other information (excluding the HMO's confidential, proprietary, or privileged information). The HMO will automatically provide the Member or Authorized Representative with any new or additional evidence considered, relied upon, or generated by the HMO 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 Authorized Representative at no charge.

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

- **Urgent Care** - In the appeal context, Urgent Care is 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 request an internal expedited appeals and also proceed with an expedited external review at the same time.

- **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 –** The determination 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, or Authorized Representative 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 titles and qualifications of the individuals who decided the appeal and those of the same or similar specialist consultant, if applicable, and their understanding of the nature of the appeal. The Member or Authorized Representative may request in writing, at no charge, the name(s) of the individual(s) who participated in the decision to uphold the denial and the name of the same/similar specialist consultant, if applicable, who acted as a consultant in the appeal review.

- **Appeal Classifications**. There are two classifications of appeals – Appeals of an Administrative Denial and Medical Necessity Appeals - established by Pennsylvania state laws and regulations are described in detail in separate sections below. An Appeal of an Administrative Denial may be filed to challenge a denial based on a contract limitation, prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy, certain surprise medical bills received by a Member from an out-of-network provider, rescissions of coverage (except for failure to pay premiums or coverage contributions) or to complain about other aspects of health plan policies or operations that has not been resolved by the Plan and has been filed with the Pennsylvania Insurance Department (PID). A Medical Necessity Appeal may be filed when the denial of a covered service is based primarily on Medical Necessity, Experimental/Investigative exclusions, or cosmetic exclusions.

You may question the classification of your appeal as an Appeal of an Administrative Denial or Medical Necessity Appeal 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 Insurance Department at:

Pennsylvania Insurance Department
Bureau of Health Care Access,
Administration, and Appeals (HCA3)
1311 Strawberry Square
Harrisburg, PA. 17120
Toll Free: 1-888-466-2787
Fax: 1-717-787-8555
E-Mail:RA-INHCA3@pa.gov

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

Appeals are also subject to the following classifications that affect the time available to conduct the appeal review:

A **pre-service** appeal is any appeal for benefits with a coverage requirement that Preapproval or precertification by the HMO must be obtained before medical care and services are received.

A **post-service** appeal includes any appeal regarding benefits for medical care or services that a Member has already received or any appeal for a service that does not require Preapproval or precertification by the HMO.

MEMBER COMPLAINT AND APPEAL PROCESSES

Informal Member Complaint Process

The HMO will make every attempt to answer 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 your request. If you are not satisfied with the response to your concern from the HMO, you have the right to file a formal appeal through the Member's formal Appeal of an Administrative Denial process described below.

Formal Member Appeal of an Administrative Denial

You may file a formal Appeal of an Administrative Denial for an unresolved dispute or objection. The Appeal of an Administrative Denial process consists of two (2) internal levels of review by the HMO, and one external level of review by the Pennsylvania Insurance Department.

Internal Standard First Level Appeal of an Administrative Denial

The Member or Authorized Representative may file a formal, first level standard Appeal of an Administrative Denial 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 Process** described above. To file a first level standard Appeal of an Administrative Denial call Customer Service toll free at the telephone number listed on your ID Card, or call, write or fax the Member Appeals Department as follows:

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

You or your Authorized Representative may submit an oral or written appeal. Additionally, you or your Authorized Representative may submit written data or other information to the HMO for consideration regarding the appeal. The HMO will acknowledge receipt of your Appeal of an Administrative Denial in writing.

The First Level Appeal of an Administrative Denial Committee will complete the review of the standard appeal and send notification to you or your Authorized Representative 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 Appeal of an Administrative Denial 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 **five (5) business days** of the date the decision was made. If your appeal is denied, the decision letter states: (1) the specific reason for the decision; (2) the HMO Program's provision on which the decision is made and instructions on how to access the provision; and, (3) how to appeal to the next level if you are not satisfied with the decision.

Internal Standard Second Level Appeal of an Administrative Denial

If you or you Authorized Representative are not satisfied with the decision from the first level Appeal of an Administrative Denial, you, or your Authorized Representative may file a second level appeal to the Second Level Committee within **sixty (60) calendar days** of your receipt of the First Level Committee's decision from the HMO. To file a second level Appeal of an Administrative Denial, call, write or fax the Member Appeals Department at the address and telephone numbers listed above.

You or your Authorized Representative may submit an oral or written appeal. Additionally, you or your Authorized Representative may submit written data or other information to the HMO for consideration regarding the appeal.

The HMO sends a written acknowledgement of receipt of the appeal request to the Member or Authorized Representative.

Upon receipt of your appeal, you or your Authorized Representative will be notified in writing in advance of a date and time scheduled for the Second Level Appeal of an Administrative Denial Committee meeting. You or your Authorized Representative may request a change in the meeting schedule. We will do our best to accommodate the request while remaining within the established timeframes. If you or your Authorized Representative do not participate in the meeting, the Second Level Committee will review your Appeal of an Administration Denial and make a decision based on all available information.

The Second Level Appeal of an Administrative Denial Committee meets and renders a decision on your standard appeal and notifies you or your Authorized Representative 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 Appeal of an Administrative Denial 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 Appeal of an Administrative Denial Committee members will include the HMO's staff, with one third of the committee being other persons who are not employed by the HMO. You or your Authorized Representative may submit supporting materials both before and at the appeal meeting. Additionally, you or your Authorized Representative have the right to review all information considered by the committee that is not the HMO's confidential, proprietary or privileged information.

The Second Level Appeal of an Administrative Denial 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.

You have the right to present your Appeal of an Administrative Denial to the committee via video conference or by way of a conference call. Your appeal can also be presented by your provider or another Authorized Representative. The HMO will attempt to contact you to schedule the Second Level Complaint Committee meeting for your Appeal of an Administrative Denial.

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 Authorized Representative or to provide general, personal assistance. Members or their Authorized 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 Appeal of an Administrative Denial Committee on your standard appeal within five (5) business days of the date the decision was made. The notice will include the basis for the denial and the procedure for appealing the decision to the Pennsylvania Insurance Department, Bureau of Health Care Access, Administration and Appeals (HCA3) or the Bureau of Consumer Affairs. The Member may be represented by an attorney or other individual in the state review. The decision is final unless you choose to appeal to the Pennsylvania Insurance Department as described in the decision letter. (See also **External Appeal of an Administrative Denial** below.)

External Appeal of an Administrative Denial

If you are not satisfied with the decision of the internal Second Level Appeal of an Administrative Denial Committee you have the right to an external appeal. Your external Appeal of an Administrative Denial is to be filed within **(15) calendar days of your receipt of the final adverse decision letter** in writing to the Pennsylvania Insurance Department (PID) at the addresses noted below:

Pennsylvania Insurance Department
Bureau of Health Care Access,
Administration and Appeals(HCA3)
1311 Strawberry Square
Harrisburg, PA. 17120
Toll Free: 1-888-466-2787
Fax: 1-717-787-8555
E-Mail: RA-INHCA3@pa.gov

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

Your request for an external review of a Appeal of an Administrative Denial should include your name, address, daytime telephone number, the name of the HMO as your health 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 appeal review to the HMO and copies of any correspondence and decision letters from the HMO.

When an external Appeal of an Administrative Denial review request is submitted to the Pennsylvania Insurance Department's HCA3 or Bureau of Consumer Services, 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 review will provide you and the HMO with a copy of the final determination of its decision.

All records from the internal Appeal of an Administrative Denial process are transmitted by the HMO to the HCA3 via the HCA3 Portal.

MEDICAL NECESSITY APPEAL PROCESS

Formal Member Appeal Process for Decisions Based On Medical Necessity

Members/Authorized Representatives may file a formal Medical Necessity 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 (including appropriateness, health care setting and level of care or effectiveness).

This appeal process consists of one (1) internal review by the HMO and, if appealed further, an external review conducted by an accredited private Independent Review Organization (IRO). The external review is coordinated by the Pennsylvania Department of Insurance's HCA3.

There is also an internal and external expedited Medical Necessity Appeal process in the event your condition involves an urgent issue.

Internal Standard Medical Necessity Appeals

You or your Authorized Representative may file a standard Medical Necessity Appeal within **one hundred eighty (180) calendar days** from the date of receipt of the original denial by the HMO. To do so, call Customer Service at the toll-free telephone number listed on your ID Card, or call, write or fax the Member Appeals Department as follows:

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

The HMO will acknowledge receipt of your Medical Necessity appeal in writing. This confirmation advises that the HMO considers the matter to be a Medical Necessity Appeal and that the Member or Authorized Representative may question the classification by contacting the HCA3. or the Bureau of Consumer Services at the information listed above.

Your one level of internal appeal is reviewed by an HMO Medical Director who is the decision-maker. This individual holds an active unrestricted license to practice medicine, has had no previous involvement in the case, and is not a subordinate of the person who made the original determination. Additionally, the HMO Medical Director is a same or similar specialist, or the decision-maker receives input from a consultant who is a same or similar specialist. A same or similar 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 same or similar specialist Physician is a consultant, their opinion on the Medical Necessity Appeal will be reported to the HMO in writing for consideration. You or your Authorized Representative may request a copy of the same or similar specialist's opinion in writing, and it will be provided to you or Authorized Representative prior to the date of review by the HMO Medical Director. The same or similar specialist's report includes their credentials as a licensed Physician or Psychologist, such as board certification.

The HMO Medical Director completes the review of your standard appeal and sends notification to you or your Authorized Representative within:**(1) thirty (30) calendar days** from receipt of a standard appeal request; and (2) within **seventy two (72) hours** from receipt of a standard non-formulary exception appeal request.

You or your Authorized Representative will be sent the decision on your internal appeal in writing within five (5) business days of the determination. If your Medical Necessity Appeal is denied, the decision letter states: (1) the specific reason for the denial; (2) the HMO Program's provision on which the decision is made and instructions on how to access the provision; and, (3) how to request an external review if you are not satisfied with the decision.

Internal Expedited Medical Necessity Appeals

If your case involves an Urgent Care condition, then you or your physician (or other Authorized Representative) may ask to have your case reviewed in a faster manner, as an expedited Medical Necessity Appeal. The HMO also grants an expedited Medical Necessity Appeal review for all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility. There is one internal level of appeal review for an expedited Medical Necessity 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 Medical Necessity Appeal 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 Medical Necessity Appeal.

The decision process for an expedited Medical Necessity Appeal mirrors the one described above for the standard Medical Necessity Appeal.

The expedited Medical Necessity Appeal review is completed promptly based on your health condition. The HMO conducts an expedited internal review and issues a decision to the Member, Authorized Representative, and practitioner/provider within **seventy-two (72) hours** of the date the HMO received the appeal. For non-formulary exception requests, the appeal is decided and notification sent within **twenty-four (24) hours** of receipt of the request. The notification includes the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

EXTERNAL APPEAL PROCESS

External Appeal Process For Decisions Based On Medical Necessity

You or your Authorized Representative may file a written request for an external appeal with HCA3 within four (4) months of their receipt of the HMO's Adverse Benefit Determination or final Adverse Benefit Determination for an internal Medical Necessity Appeal. The HCA3 contracts directly with the IRO and notifies the HMO of the assignment for each case file. The HCA3 is also responsible for keeping IRO pricing at a reasonable level.

Please refer to your final internal appeal adverse benefit determination letter for specific instructions on how to file your appeal with the HCA3.

A Member/Authorized Representative may only request an external review after exhausting the HMO's internal appeal process. The Member/Authorized Representative shall be deemed to have exhausted the HMO's internal appeal process in the following circumstances:

- The Member/Authorized Representative has filed a Medical Necessity Appeal.
- Except to the extent the Member or their Authorized Representative has requested or agreed to a delay, the HMO has not issued a decision to the Member or Authorized Representative within thirty (30) calendar days of when the Member filed the appeal with the HMO.
- The HMO waives its requirement that the Member/Authorized Representative must exhaust the internal claim and appeal process prior to filing a request for an external review or expedited external review.
- The HMO has failed to comply with the requirements of the internal claims, utilization review and/or appeals process unless the failure or failures are based on de minimis violations that do not cause and are not likely to cause prejudice or harm to the Member/Authorized Representative.

Preliminary Review of an External Review Request

The HCA3 will send a copy of the external review request to the HMO within one (1) business day of receipt of the request. Within five (5) business days of the HMO's receipt of this copy, the HMO will perform a preliminary review to determine whether:

- The individual is or was a Member under the health insurance policy at the time the health care service was requested, or in the case of a retrospective utilization review, at the time the health care service was provided.
- The health care service that is the subject of the external review request is covered under the Member's health insurance policy, except for determinations by the HMO that a health care service

is not covered because it does not meet the HMO's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

- The Member has exhausted the HMO's internal Medical Necessity Appeal process.

- The Member has not provided all required information and forms to process an external review.

For an external review of denial of coverage of an experimental or investigational treatment, the HMO's preliminary review will also include a determination of whether:

- The health care service is covered under the Member's health insurance policy, except for the HMO's determination that the health care service is experimental or investigational for a particular condition.

- The health care service is not explicitly listed as an excluded benefit under the Member's health insurance policy.

- The Member's treating Health Care Provider has certified that one of the following situations is applicable:

    - Standard health care services have not been effective in improving the condition of the Member.

    - Standard health care services are not medically appropriate for the Member.

- There are no available standard health care services under the health insurance policy that are more beneficial than the recommended or requested health care services described in the next paragraph.

- The Member's treating Health Care Provider either:

    - Has recommended health care services that the Health Care Provider certifies, in writing, are more likely to be beneficial to the Member, in the Health Care Provider's opinion, than available standard health care services.

    - Has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care services requested by the Member who is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination, are likely to be more beneficial to the Member than any available standard health care services, when the treating Health Care Provider is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the Member's condition.

External Review Process

Within one (1) business day of completion of the preliminary review, the HMO notifies the HCA3, the Member/Authorized Representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the HMO notifies the Member/Authorized Representative and HCA3 in writing, including what information or materials are needed to make the request complete.

- If the request is not eligible for an external review, the HMO informs the Member/Authorized Representative and the HCA3 in writing, including the reason(s) why the request is not eligible.

- The Member/Authorized Representative may appeal the HMO's initial determination that the external review request is ineligible for review to the HCA3.

- Despite the HMO's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the HMO and the Member and may be appealed to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

Within one business day of the HCA3's receipt of the HMO's notification that the external review is eligible based on the HMO's preliminary review, the HCA3 assigns an IRO to review the case file and notifies the HMO of the assignment.

The HCA3 sends written notification to the Member/Authorized Representative of the eligibility of the request based on the preliminary review and of the name and contact information of the assigned IRO. Additionally, the HCA3 notifies the Member/Authorized Representative they may send the IRO additional information within fifteen (15) business days of receipt of the HCA3's notification. Within one (1) business day of receiving additional information from the Member/Authorized Representative, the IRO sends a copy of the information to the HMO.

Within five (5) business days of receipt of the name of the assigned IRO from the HCA3, the HMO provides the assigned IRO with all the documents and information considered in making an Adverse Benefit Determination or the final Adverse Benefit Determination. If the HMO fails to provide the assigned IRO with the documents and information within that timeframe, the IRO may proceed with the external review, terminate the external review, and overturn the HMO's decision. The IRO notifies the Member/Authorized Representative, the HCA3, and the HMO of the action they have taken within one (1) business day of making their decision.

Reconsideration by the HMO

Upon receipt of additional information forwarded by the IRO, the HMO may reconsider the Adverse Benefit Determination that is the subject of the external review. Reconsideration by the HMO may not delay or terminate the external review.

An external review may be terminated without an IRO determination if the HMO overturns their decision that is the subject of the external review and provides coverage or payment for the recommended health care service that is the subject of the external review. Within one (1) business day of deciding to overturn their decision, the HMO will notify the HCA3, IRO, and the Member/Authorized Representative in writing of its decision. The assigned IRO will terminate the external review upon receive of this notice.

External Review IRO Decision

The assigned IRO makes a decision and sends notification to the Member/Authorized Representative within forty-five (45) calendar days of receipt of the external review request. For an external review of Experimental/Investigational Treatment, the assigned IRO makes a decision and sends notification to the Member/Authorized Representative within twenty (20) calendar days of receipt of the external review of Experimental/Investigational Treatment request. For non-formulary exception requests, the IRO makes a decision and sends notification within seventy-two (72) hours of receipt of the request.

Upon receipt of an IRO overturn decision, the HMO will approve the request that was the subject of the external review within twenty-four (24) hours.

Expedited External Review

You or your Authorized Representative may make an oral or written request to the HCA3 for an expedited external review. A retrospective case is not eligible for an expedited external review.

A Member/Authorized Representative may request an expedited external review in the following circumstances:

- The Member has an Urgent Care condition for which the time for a standard external review decision would seriously jeopardize the life, or health of the Member or jeopardize their ability to regain maximum function.

- The final Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which a Member receives emergency care but has not been discharged from a facility.

Please refer to your final internal appeal adverse benefit determination letter for specific instructions on how to file your appeal with the HCA3.

A Member/Authorized Representative may request an expedited external review at the same time as the expedited internal Medical Necessity Appeal process in the following circumstances:

- The Member has an Urgent Care condition for which the timeframe for completion of an expedited internal review of the Adverse Benefit Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.

- The final Adverse Benefit Determination involves a determination that the recommended or requested health care service is experimental or investigational, and the Member's treating Health Care Provider certifies in writing that the recommended or requested health care service that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Preliminary Review of an Expedited External Review Request

Upon receipt of an expedited external review, the HCA3 sends a copy of the request to the HMO within twenty-four (24) hours.

- Within twenty-four (24) hours of receipt of the request from the HCA3, the HMO determines if the request meets the requirements for an external review and notifies the HCA3 and Member/Authorized Representative of the HMO's eligibility determination.

    - The Member/Authorized Representative may appeal the HMO's initial determination that the external review request is ineligible for review to the HCA3.

    - Despite the HMO's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the HMO and the Member and may be appealed to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

Expedited External Review Process

Upon receipt of the HMO's notification that the request meets the eligibility requirements, the HCA3 assigns an IRO to conduct the expedited external review within twenty-four (24) hours.

The HMO forwards all documents from an Adverse Benefit Determination or final Adverse Benefit Determination to the assigned IRO by the following methods:

- Electronically (typically via the assigned IRO portal)
- By any other available expedited method, if no IRO portal is available.

Expedited External Review IRO Decision

Within seventy-two (72) hours of receipt of the request, the IRO makes their decision and notifies the Member/Authorized Representative, the HCA3, and the HMO. For non-formulary exception request, the IRO makes their decision within twenty-four (24) hours of the request and notifies the Member/Authorized Representative, the HCA3, and the HMO.

Upon receipt of an IRO overturn decision, the HMO will approve the request that was the subject of the expedited external review within twenty-four (24) hours.

Binding Decision for External Reviews

An IRO decision is binding on the HMO except to the extent the HMO has other remedies available under applicable state law. An IRO decision is binding on the Member/Authorized Representative, except to the extent the Member/Authorized Representative has other remedies available under applicable Federal and state laws.

Neither the Member nor the Authorized Representative may file a subsequent request for an external review involving an Adverse Benefit Determination or final Adverse Benefit Determination for which the Member has already received a decision for the same Adverse Benefit Determination or final Adverse Benefit Determination.

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:
            (1) 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,
            (2) 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:
(1) First, the contract of the parent with custody of the child;
(2) Then, the contract of the spouse of the parent with custody of the child;
(3) 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 Agreement, 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 providing high-quality, accessible, and cost-effective care through the PCP Quality Incentive Payment System (QIPS) program. QIPS includes incentives for performance in over twenty (20) HEDIS measures and cost and care efficiency management, including medical cost, pharmacy cost, ED utilization, and transitions of care.

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, delivery and post-partum care.

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, laboratory, radiology, 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.

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 may receive Covered Services provided by a Non-Participating Hospital-Based Provider. For such Covered Services, the HMO will reimburse the Non-Participating Hospital-Based Provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The Member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the Non-Participating Hospital-Based Provider, and the Non-Participating Hospital-Based Provider cannot ask the Member to give up their protections not to be balanced billed.

If the Member receives other services at a Participating Hospital or other Participating Facility Provider, Non-Participating Providers cannot balance bill the Member, unless the Member gives written consent and gives up the protections not to be balanced billed.

Air Ambulance Providers: For air ambulance services provided by a Non-Participating Provider, if such air ambulance services would be covered if provided by a Participating Provider, the Member is protected from surprise billing or balance billing and will be subject to the in-network cost-sharing levels. The HMO will reimburse the Non-Participating Provider based upon the methodology established by the Consolidated Appropriations Act (CAA). In these situations, the Member cannot be balanced billed for the air ambulance services provided by a Non-Participating Provider.

Emergency Care by Non-Participating Providers: If the HMO determines that Covered Services provided by a Non-Participating Provider were for Emergency Care, the Member is protected from surprise billing or balance billing and will be subject to the in-network cost-sharing levels.

If Emergency Care is provided by certain Non-Participating Providers (For example, ambulance services), in accordance with applicable law, the HMO will reimburse the Non-Participating Provider based upon the methodology established by the Consolidated Appropriations Act (CAA). In these situations, the Member cannot be balanced billed for the Emergency Services. This includes services the Member may receive after the Member is in stable condition, unless the Member gives written consent and gives up the protections not to be balanced billed for these post-stabilization services.

Institutional Providers:
Hospitals: For most inpatient medical and surgical Covered Services, most Hospitals are paid either a case rate, which is a set dollar amount paid based on the Diagnostic Related Group (DRG) for a complete Hospital stay related to a specific procedure or diagnosis, or a per diem rate, which is a specific amount paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of services provided.

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 value-based payment (VBP) program through an Integrated Delivery System. The VBP program includes hospital-based quality and patient satisfaction measures, including Plan All-Cause Readmission (PCR) and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which are intended to measure improved patient outcomes and transitions of care and satisfaction.

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.

Integrated Delivery Systems: 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 may participate in a shared savings and deficit value-based payment (VBP) program designed to promote care coordination, healthcare quality, and increased efficiency. The IDS is paid eligible incentive earnings based on the management of costs of 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. These IDSs may provide incentives to their IDS-affiliated Professional Providers for meeting certain quality, service or other performance standards.

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. In addition to the IPA, we have entered into “at risk” agreements with group practices and/or risk bearing entities.

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:

Facility and Hospital Providers

Almost all Behavioral Health Facility and Hospital Providers are paid specific all-inclusive per diem rate for services rendered based on the contract with the Provider. A subset of psychiatric facility or hospital providers will participate in new value-based incentive program — the Mental Health Incentive Program (MHIP).

Professional Providers

All solo Behavioral Health practitioners and most Behavioral Health Group practices are paid fee-for-service according to standard fee schedule or non-standard fee schedule specific to the Provider or Group Practice. Other Behavioral Health Group practices are paid a weekly or monthly case rate for services rendered by a team of different Behavioral Health clinical disciplines.

Many Pennsylvania based Mental Health providers are also eligible to receive additional payments for providing high-quality, accessible, and cost-effective care through the Mental Health Incentive Program (MHIP). MHIP includes incentives for performance in patient access and retention measures and cost and care efficiency management, including ED utilization, inpatient utilization and follow-up care.

Pharmacies: A pharmacy benefits management company (PBM) administers our Prescription Drug benefits, and is responsible for providing a network of Participating Pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. 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 their 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
2. A child, including stepchild, legally adopted child, child placed for adoption, or natural child, of either the Subscriber or the Subscriber's spouse, who is within the Limiting Age for Dependents as set forth in 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 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 their 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.

7. A Domestic Partner, as long as the Domestic Partnership exists, the child or children of a Domestic Partner shall be considered for eligibility under the Program as if they were the Member's own child or children. If the Member enrolls their Domestic Partner, the Member has an affirmative obligation to notify the HMO immediately if the Domestic Partnership terminates.

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.

B. **Adding A Dependent Child**
A newborn child or adopted child of a Member shall be entitled to benefits for the first thirty-one (31) days immediately following birth of the newborn or adopted child. To be eligible for Dependent coverage beyond the thirty-one (31) day period, the Applicant must enroll the newborn child or adopted child as a Dependent within such thirty-one (31) days and any appropriate payment due, calculated from the 32nd day after birth, is received by the HMO.

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. **Termination of a Domestic Partnership**
Upon termination of the Domestic Partner relationship, coverage of the former Domestic Partner and the children of the former Domestic Partner shall terminate at the end of the current monthly term. The former Domestic Partner, and any of their previously covered children, shall be entitled, by applying within sixty (60) days of such termination, to conversion coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This conversion coverage may be different from the coverage provided under this Agreement.

F. **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.

G. **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.

H. **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:
1. Name
2. Address
3. Status or number of Dependents
4. Marital status
5. Eligibility for Medicare

I. **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 Appeal of an Administrative Denial and Medical Necessity Appeal Processes;

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 Appeal of an Administrative Denial and Medical Necessity Appeal Processes. 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 the 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 Appeal of an Administrative Denial and Medical Necessity Appeal Processes. 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, Coinsurance or Deductible, 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.

This plan has a Tiered Network. Your cost share may be different based on the tier of the Provider you receive services from. Participating Providers under this plan may be part of a selected subset, or tier, of the HMO's entire network of Participating Providers. Providers may be classified as Tier 1, Tier 2, or Tier 3.
This plan offers three different levels of In-network benefits based on the tier designation of the Participating Provider you receive services from. Your cost sharing (Copayment, Deductible and/or Coinsurance) will be lower for use of Tier 1 Providers, than for Tier 2 and Tier 3. In order to take advantage of the lower cost sharing for use of a Tier 1 Hospital it will be important to select a PCP and Specialist who have admitting privileges at the Tier 1 Hospital when Hospitalization becomes necessary. For services received as a result of an Emergency, if the Member is admitted to a Participating Hospital from the Emergency Room, the cost-sharing for inpatient hospital care, including Medical Care provided by a Participating Professional Provider, will apply based on the tier level of that provider, whether the provider is a Participating Hospital or a Participating Professional Provider. Section MC – Using the HMO System provides more detail regarding Provider Tiers.

To find a list of Participating Providers with their tier designation, log onto the HMO website at www.ibx.com/FindaDoctor, or you can call Customer Service at the phone number listed on your ID Card to have a Provider Directory mailed to you.

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:

A. The American Academy of Pediatrics;
B. The American College of Physicians;
C. The U.S. Preventive Services Task Force; and
D. 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 the Preventive Schedule document at any time after written notice of the change has been given to you.

Office Visits/Telemedicine 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.

For the purpose of this benefit, "Telemedicine Visits" include Medical Care visits when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA) - compliant interactive audio and video telecommunications system as specified in the HMO's policies.

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:

A. **Routine Gynecological Exam, Pap Smear**. 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. Members have "direct access" to care by a Participating Obstetrician or Gynecologist. This means there is no Primary Care Physician Referral needed.
B. **Mammograms**. Coverage will be provided for screening 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.
C. **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.
D. **Contraception**: The Women's Preventive Services Initiative recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care. The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration (FDA) include:
    1. Sterilization surgery for women;
    2. Surgical sterilization implant for women;
    3. Implantable rod;
    4. IUD copper;
    5. IUD with progestin;
    6. The shot or injection;
    7. Oral contraceptives (combined pill);
    8. Oral contraceptives (progestin only, and);
    9. Oral contraceptives (extended or continuous use);
    10. The contraceptive patch;
    11. Vaginal contraceptive rings;
    12. Diaphragm;
    13. Contraceptive sponges;
    14. Cervical caps;
    15. Female condoms;
    16. Spermicides;
    17. Emergency contraception (levonorgestrel); and
    18. Emergency contraception (ulipristal acetate).

Although all Food and Drug Administration-approved contraceptive methods and patient education and counseling are covered, only certain contraceptive drug options in each category are covered 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. Abortifacients are not considered contraceptives.

If a 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:
A. Pediatric immunizations;
B. Adult immunizations (except those required for employment or travel);
C. 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
Benefits are provided for nutrition counseling visits/sessions 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.

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:

A. Medically Necessary;
B. Provided or Referred by your Primary Care Physician; and
C. 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 or 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 Facility Services
Benefits are provided for a Participating Skilled Nursing 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 Facility.

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

Should your Primary Care Physician or Participating Specialist agree with the HMO that continued stay in a Skilled Nursing Facility is no longer required, you will be notified in writing of this decision. Should you decide to remain in the facility after its notification the facility has the right to bill you after the date of the notification. You may appeal this decision through the Medical Necessity Appeal Process.

INPATIENT / OUTPATIENT COVERED SERVICES

Services for Inpatient / Outpatient Care are Covered Services when:
A. Medically Necessary;
B. Provided or Referred by your Primary Care Physician; and
C. 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.

Autism Spectrum Disorders (ASD)
The HMO will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for the Members when provided or Referred by the Primary Care Physician for the development of an ASD Treatment Plan. Treatment of Autism Spectrum Disorders must be:
A. Prescribed, ordered or provided by a Participating Professional Provider, including the Member's Primary Care Physician, Referred Specialist, licensed physician assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner;
B. Provided by an Autism Service Provider, including a Behavioral Specialist; or
C. Provided by a person, entity or group that works under the direction of an Autism Service Provider.

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

A. Applied Behavioral Analysis – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
B. Pharmacy Care - means the following when Prescribed and/or ordered by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner who is a Participating Professional Provider:
   1. Medications; and
   2. Any assessment, evaluation or test to determine the need or effectiveness of such medications.

   If this Program provides benefits for Outpatient Prescription Drugs through this Program or under a Freestanding Prescription Drug agreement issued by an affiliate of Keystone, the ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable under a Prescription Drug benefit.

C. Psychiatric Care – Direct or consultative services provided by a Physician specializing in psychiatry who is a Participating Professional Provider.
D. Psychological Care – Direct or consultative services provided by a Psychologist who is a Participating Professional Provider.
E. Rehabilitative Care – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
F. Habilitative Care – Health care services provided by an Autism Service Provider that help an individual to keep, learn, or improve skills and functioning for daily living.
G. Therapeutic Care – Services provided by a speech language pathologist, occupational therapist or Physical Therapist who is a Participating Professional Provider.

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

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed in accordance with either of the following:
A. A documented diagnosis can be made by a qualified licensed treating professional provider including a psychiatrist, pediatrician, pediatric neurologist, family practice physician, child psychiatrist or psychologist, psychiatric-behavioral health nurse practitioner consistent with state licensing requirements.
B. The documented diagnosis incorporates the results of a validated autism assessment measures. Validated autism assessment measures may be performed by a qualified licensed professional provider including master's (e.g., social worker, licensed professional counselor), physicians, psychologists, certified nurse practitioners, or psychiatric mental health nurse practitioners, as is consistent with state licensing requirements.

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a Member shall be entitled to file an appeal. The appeal process will:
A. Provide internal review followed by independent external review; and,
B. Have levels, expedited and standard appeal time frames, and other terms established by the Health Benefit Plan consistent with applicable Pennsylvania and federal law.

Appeal filing procedures will be described in notices denying any Autism Spectrum Disorders benefits. Full appeal process descriptions will be provided after a new appeal is initiated and can also be obtained at any time by contacting Customer Service.

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:

A. 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
B. 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 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. Abortion Services
   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 termination of your pregnancy to prevent the death of the woman, or to terminate a pregnancy caused by rape or incest 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 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 Section SC -Schedule of Cost Sharing & Limitations 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).

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

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

1. For the treatment of a mental illness, including a Serious Mental Illness;
2. 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.

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

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

1. For the treatment of a Mental Illness, including a Serious Mental Illness;
2. 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, Telebehavioral Health services, 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.

Methadone Treatment
Provision and supervision of methadone hydrochloride in prescribed doses for the treatment of opioid dependency.

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" provision.

E. Oral Surgery
   The HMO will provide coverage for Covered Services provided by a Professional Provider and/or Facility Provider for:

1. Orthognathic surgery – Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
   a. For accidents: The initial treatment of Accidental Injury or trauma (That is, fractured facial bones and fractured jaws), in order to restore proper function.
   b. For congenital defects: In cases where it is documented that a severe congenital defect (That is., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
   c. For chewing and breathing problems: 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.

To the extent that the member has available dental coverage, the HMO reserves the right to seek recovery from the provider.

The HMO has the right to decide which facts are needed. The HMO may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the HMO deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the HMO such information as may be necessary to implement this provision.

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:
    1. Removal of the organ;
    2. Preparatory pathologic and medical examinations; and
    3. 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 (TTY: 711).

A. <u>Inpatient Alcohol Or Drug Abuse And Dependency Treatment</u>
    Benefits are provided for Covered Services during an Inpatient Alcohol Or Drug Abuse And Dependency Treatment admission:
    1. For the diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency, including Detoxification; and

2. 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:
1. Lodging and dietary services;
2. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
3. Services provided by a staff Physician, Psychologist, registered or licensed practical nurse, and/or certified addictions counselor;
4. Rehabilitation therapy and counseling;
5. Family counseling and intervention; and
6. Prescription Drugs, medicines, supplies and use of equipment provided by the 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.

B. 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:
1. 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
2. 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:
1. Diagnostic services, including psychiatric, psychological and medical laboratory tests;
2. Services provided by the Behavioral Health/Alcohol Or Drug Abuse And Dependency Providers on staff;
3. Telebehavioral Health services;
4. Rehabilitation therapy and counseling;
5. Family counseling and intervention; and
6. 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:
A. Medically Necessary;
B. Provided or Referred by your Primary Care Physician; and
C. 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/Transport
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 endanger the Member's health or be inappropriate for the Member'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.

In addition, the HMO will provide coverage for services provided by a licensed emergency services provider who initiates necessary intervention to evaluate and, if necessary, stabilize the condition of the Member and subsequently determines the Member does not require transport or the Member refuses to be transported. These services must be Medically Necessary as determined by the HMO.

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:
   a. Non-emergency air or ground facility to facility transport to the nearest appropriate facility that is capable of addressing the Member's medical needs may be covered when Medically Necessary as determined by the HMO (e.g. sending facility does not have the required services to effectively treat the Member, such as trauma or burn care).
   b. Non-emergency air or ground transport may be covered to transport the Member back to a Participating Facility Provider in the Member's local Service Area as determined by the HMO, when:

      (1) The transfer is Medically Necessary (as determined by the HMO definition of Medical Necessity); and

(2) The Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance; and
(3) Non-emergency ambulance transports are not provided for family members or companions, or for the convenience of the Member, the family, or the Provider treating the Member.

Consumable Medical Supplies
The HMO will provide coverage for the purchase of Consumable Medical Supplies when:
A. It is used in the Member 's home; and
B. It is obtained through a Participating Durable Medical Equipment Provider.

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 their 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 Deductible, 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, mammograms, 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). Benefits are provided, without cost sharing when provided by a Participating Provider, for diagnostic breast examinations because the Member is believed to be at an average or increased risk of breast cancer;
B. Non-Routine Diagnostic Services, such as Nuclear Cardiology Imaging, Magnetic Resonance Imaging/Magnetic Resonance Angiography (MRI/MRA), Positron Emission Tomography (PET Scan), Sleep Studies, and Computed Tomography (CT Scan). Benefits are provided, without cost sharing when provided by a Participating Provider, for diagnostic breast examinations because the Member is believed to be at an average or increased risk of breast cancer; 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 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.

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, Coinsurance or Deductible 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; and some Generic Drugs are included in this category and are subject to the Specialty Drug cost-sharing**.**

1. Specialty Drugs can be categorized into different drug classes, including Gene Replacement Therapies. To obtain a list of Specialty Drugs, please go to www.ibx.com/resources/for-providers/policies-and-guidelines/pharmacy-information/specialty-drugs or call the Customer Service telephone number shown on the Member's ID Card.

2. Gene Replacement Therapies are eligible for coverage under the medical benefit and require Preapproval from the HMO. The HMO has an established network of providers to administer Gene Replacement Therapies and can be found at: Gene-based therapies | Independence Blue Cross (ibx.com). Gene Replacement Therapies that are eligible for coverage are included on the Preapproval list. This list can be found at: https://www.ibx.com/resources/for-providers/policies-and-guidelines/operations-management/preapproval-requirements.

Dual Coverage: Coverage and costs: The HMO will provide coverage for an injectable medication in accordance with Medical Policy coverage criteria and the terms and conditions of this Agreement. This is subject to any applicable Deductible, Copayment and/or Coinsurance or Preapproval requirements:

1. If the drug is covered under the Injectable Medication benefit of this Agreement and is administered by a healthcare Provider in a Hospital Outpatient facility, provider's office, ambulatory (or free-

standing) infusion suite, home (through a home infusion vendor), inpatient Hospital, or any other health care facility, this drug is eligible for coverage under the medical benefit:

a. Injectable medications are subject to the cost-share specified in the Section SC - Schedule of Cost Sharing & Limitations.

2. Certain injectable medications may have a different formulation that is deemed eligible for coverage under the prescription drug benefit, if the benefit exists for the drug and if the Member can safely self-administer the drug without the assistance of a healthcare Provider, in accordance with the drug's prescribing information:
   a. Self-Administered drugs are subject to the cost-sharing associated with the terms of the Member's prescription drug benefit.

3. Cost-sharing amounts for a drug that may be eligible for coverage under the Member's medical benefit or prescription drug benefit may vary. Members should discuss these coverage options with their healthcare Provider. Member financial responsibilities (including Deductible, Copayment, and/or Coinsurance) depend on the terms and conditions of the Member's applicable benefit. These terms and conditions are subject to change.

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 Drugs**.** 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 shall be payable for Nutritional Formulas when the Nutritional Formula is administered through a tube.

Benefits are also payable for oral elemental formulas for 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, except coverage is not available for enhancements or deluxe supplies or convenience features that do not serve or contribute towards any clinically established physiological and/or functional improvements;
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, previous therapeutic processes, or care for conditions that federal, state or local law requires to be treated, including childhood stuttering, a speech disorder characterized by repetition of sounds, syllables or words, prolongation of sounds and interruptions in speech developed between two (2) and six (6) years of age. Coverage will also include services by a speech therapist.

Specialist Office/Telemedicine Visits
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.

For the purpose of this benefit, "Telemedicine Visits" include Medical Care visits when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA) - compliant interactive audio and video telecommunications system as specified in the HMO's policies.

Spinal Manipulation Services
Benefits are provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Therapy Services
Benefits are provided for the following forms of therapy:

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

B. **Chemotherapy**
The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. The cost of these drugs/biologics is covered, provided if it meets all of the criteria listed below:
1. Drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents.
2. The FDA- approved use is based on reliable evidence demonstrating positive effect on health outcomes and/or the use is supported by the established referenced Compendia identified in the Company's policies.
3. Drugs/biologics are eligible for coverage when they are injected or infused into the body by a professional provider.

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.

Virtual Care Services

A. **Services Provided by Contracted Vendors:**
Virtual care services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone, or secure video, when a Professional Provider is unavailable or inaccessible. These licensed providers do not replace an existing Professional Provider relationship but enhances it with an efficient, convenient alternative for non-emergency medical problems. The applicable vendor provider cost-sharing requirements are specified in the Section SC -_Schedule of Cost Sharing & Limitations. The Member will pay the applicable cost-sharing via credit or debit card prior to the consultation.

B. **Benefits Provided by Professional Provider:**
Virtual care services are also covered, when provided by a Participating Professional Provider and subject to the relevant cost share applicable to that provider. The provider's eligibility will be determined by the Health Benefits plan in the HMO's Medical Policies, who is licensed in the state where the virtual care service is being offered. Virtual care services are covered when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA)- compliant interactive audio and video telecommunications system as specified in the HMO's Medical Policies.

SECTION RX – PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits shall be available for Covered Drugs or Supplies appearing on the Drug Formulary that are dispensed based upon 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 in 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.

After the Member satisfies the Deductible, if applicable, the HMO reimburses for Covered Drugs or supplies as follows:

- **Drugs From a Participating Pharmacy** – Covered Drugs or Supplies will be furnished by a Participating Pharmacy subject to the Prescription Drug cost sharing 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. For prescriptions filled at a retail Non-Participating Pharmacy, the Member must pay the full retail price for their prescription then file a paper claim for reimbursement. 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 a designated retail pharmacy or 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 designated retail pharmacy or 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. Drugs or Supplies not listed in the Drug Formulary shall not be covered. 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 Medications** – 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 after the Deductible, if applicable, has been satisfied.

- **Specialty Drugs** – The HMO will provide benefits for covered Specialty Drugs 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 Specialty drugs obtained through a Non-Participating Pharmacy.

  * Select Specialty Drugs will be subject to "split fill" for the initial/subsequent fills. Each prescription may be dispensed in two separate amounts. The first amount is dispensed without delay. The second amount may be dispensed subsequently, allowing time for any necessary clinical intervention due to medication side effects that may require dose modification or therapy discontinuation. The Member's cost-share is prorated for each amount of the "split fill".

- 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.

- **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 certain generic products and brand products approved by the Federal Food and Drug Administration, covered at no cost-share to the Member when obtained from a 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 contraceptive products.

The HMO shall determine which specialty Pharmacy and/or other Pharmacies and/or healthcare providers can dispense or administer certain Specialty Drugs.

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:
A. Whether a particular Prescription Drug appears on the Drug Formulary; or
B. How to request an exception by calling Customer Service at the phone number listed on the back of the Member's ID Card.

Information about criteria and how cost-share will be determined for formulary exceptions can be found in the Formulary Exception Policy at www.ibx.com/formularyexceptionspolicy. The Member may request a hardcopy of the policy or obtain information about how to request an exception by calling Customer Service at the phone number on the Identification Card.

The HMO will not transfer a Prescription Order from a Participating Pharmacy to another Pharmacy unless requested by the Member.

A Pharmacy may not charge the Member an amount for a Covered Drug or Supply that exceeds the amount the Member would pay for the Covered Drug or Supply without insurance.

The Member, or their Physician acting on their behalf, may appeal any denial of Benefits through the Member Appeal of an Administrative Denial and Medical Necessity Appeal Processes described in the Subscriber Agreement.

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 Deductible or 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.

A Member who receives Pediatric Vision services from a Participating Provider can elect to utilize a Non-Participating Provider for related Pediatric Vision services on the recommendation or referral of the Participating Provider, provided that the Participating Provider gives to the Member, prior to recommending, referring, Prescribing or ordering any Pediatric Vision services from the Non-Participating Provider, written notice that:

A. The Non-Participating Provider is not a Participating Provider;
B. The Member has the option of selecting a Participating Provider; and
C. The Member may have different financial obligations depending on whether the Pediatric Vision Provider is a Participating Provider or a Non-Participating Provider.

Pediatric Vision services received from a Non-Participating Provider are not covered under this HMO.

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 exclusions listed in Section EX – Exclusions, and to the provisions, limitations, and cost sharing listed in Section SC – Schedule of Cost Sharing & Limitations.

SECTION EX - EXCLUSIONS

The following are excluded from your coverage:

- Services, supplies or charges which are:
  - Not provided by or Referred by the Member's Primary Care Physician except in an Emergency; or as specified elsewhere in this Agreement;
  - 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
  - Provided by family members, relatives and friends;

- 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;

- 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;

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

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

- 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;

- 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;

- 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:
    - For dental implants for any reason;

- For dentures, unless for the initial treatment of an Accidental Injury or trauma;
- For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
- For oral devices used for temporomandibular joint syndrome or dysfunction;
- For injury as a result of chewing or biting (neither is considered an Accidental Injury);

- 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;

- 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:
  - The investigational item, device, or service, itself;
  - 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
  - A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

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

- For care in a:
  - Long-term care facility, including a:
    - Nursing home;
    - Assisted living facility; and
    - Board and care home;
  - Continuing care retirement facility;
  - Convalescent home;
  - School, with the exception of behavioral health services specified in the HMO's Medical Policies;
  - Camp, with the exception of behavioral health services specified in the HMO's Medical Policies; or
  - Institution for intellectually disabled children;

- 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;

- Any Therapy Service provided for:
  - Work hardening activities/programs;
  - Evaluations not associated with therapy;

- Vision care including, but not limited to:
  - 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;
  - For Member age nineteen (19), 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
  - Lenses which do not require a Prescription;
  - Mirror coatings;
  - Deluxe frames; or
  - Eyeglass accessories such as cases, cleaning solution and equipment;

- Immunizations required for employment purposes or travel;

- Custodial and Domiciliary Care; protective and supportive care, including educational services, rest cures and convalescent care;

- Weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary.

  This exclusion also applies to pharmacological drugs for the treatment of obesity including coverage for other FDA approved indications when the benefit to the condition is due to weight loss or the reliable evidence does not establish clinical effectiveness independent of weight loss.

  This exclusion does not apply to the HMO's weight reduction program or nutrition counseling visits/sessions as described in the Nutrition Counseling provision in this Agreement;

- For appetite suppressants;

- For oral non-elemental nutritional supplements, hydrolyzed formulas, 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;

- For elemental semi-solid foods;

- For products that replace fluids and electrolytes;

- For additives to enteral formula and food thickeners;

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

- Customized wheelchairs;

- 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;

- 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;

- Marriage or religious counseling;

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

- Ambulance Services/Transport, unless Medically Necessary and as provided in the subsection entitled “Ambulance Services/Transport” specified in Section CS – Description of Covered Services of this Agreement;

- 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;

- Charges for completion of any insurance form;

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

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

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

- 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;

- 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:
  - Rehabilitation Therapy Services (other than Speech Therapy and services for Autism Spectrum Disorders);
  - Diagnostic radiology services for Members age five (5) or older; and
  - Laboratory and pathology tests;

- 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);

- Inpatient or Outpatient Care Private Duty Nursing services;

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

- 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;

- 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;

- Services Incurred prior to the Effective Date of Coverage;

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

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

- Charges not billed and performed by a Provider;

- 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;

- For treatment of obesity, including for surgical treatment of obesity and pharmacological drugs for the treatment of obesity management. This includes, but is not limited to:
  - Weight management programs;
  - Dietary aids, supplements;
  - Weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician;
  - Group nutrition counseling.

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

- Charges in excess of benefit maximums;

- 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;

- For sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed Sex Therapist;

- With regard to Durable Medical Equipment (DME), items for which any of the following statements are true is not DME and will not be covered. Any item:
  - 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.
  - 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.
  - 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:
    - Is not durable; or
    - Is not a component of the DME.

- 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: exercise equipment; speech teaching machines; strollers; toileting systems; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.
- 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.
- 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.
- 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.
- That modifies vehicles, dwellings, and other structures. This includes:
  - Any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability; or
  - Any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
- 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.
- 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;

- With regard to Consumable Medical Supplies, any item that meets the following criteria is not a covered consumable medical supply and will not be covered:
  - The item is for comfort or convenience.
  - The item is not primarily medical in nature. Items not covered include, but are not limited to:
    - Ear plugs;
    - Ice pack;
    - Silverware/utensils;
    - Feeding chairs;
    - Toilet seats.
  - The item has features of a medical nature which are not required by the patient's condition.
  - The item is generally not prescribed by an eligible provider.

  Some examples of not covered consumable medical supplies are:
  - Incontinence pads;
  - Lamb's wool pads;
  - Face masks (surgical);
  - Disposable gloves, sheets and bags, bandages, antiseptics, and skin preparations;

- For Skilled Nursing Facility benefits:
  - 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;
  - For the treatment of Alcohol Or Drug Abuse And Dependency and Mental Illness Health Care; or

- After the Member has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care;

- For Hospice Care benefits for the following:
  - Private Duty Nursing care;
  - Research studies directed to life lengthening methods of treatment;
  - 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
  - Treatment to cure the Member's illness;

- With regard to Home Health Care services and supplies in connection with home health services for the following:
  - Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
  - Rental or purchase of Durable Medical Equipment;
  - 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;
  - Prescription Drugs;
  - Provided by family members, relatives, and friends;
  - A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
  - Emergency or non-emergency ambulance services;
  - Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
  - Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
  - 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;

- For home blood pressure machines, except for Members:
  - With pregnancy-induced hypertension;
  - With hypertension complicated by pregnancy;
  - With end-stage renal disease receiving home Dialysis; or
  - Who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates;

- 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;

- Hearing or audiometric examinations, and Hearing Aids, and the fitting thereof and, routine hearing examinations; Services and supplies related to these items are not covered. Cochlear electromagnetic hearing devices, a semi-implantable hearing aid, is not covered. Cochlear electromagnetic hearing devices are not considered cochlear implants;

- 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;

- Wigs and other items intended to replace hair loss due to androgenetic alopecia; or due to illness or injury including but not limited to injury due to traumatic or surgical scalp avulsion, burns, or Chemotherapy;

- 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;

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

- 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;

- 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;

- For health foods, dietary supplements, or diet agents;

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

- Charges for Orthoptic/Pleoptic Therapy;

- Coverage is not provided for the services or treatment related to an Elective Abortion, an abortion that is the voluntary termination of pregnancy other than one which is necessary to prevent the death of the woman, or to terminate a pregnancy that was caused by rape or incest;

- The following Exclusions apply to your Prescription Drug benefits:
  - Drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy;
  - 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:
    - Devices used for the treatment or Maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin; and
    - Devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines; or
    - Contraceptive devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordable Care Act;
  - Drugs Prescribed and administered in the Physician's office;
  - 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 certain drugs that are specifically designated by the HMO, whether or not Prescribed by a Physician;
  - Any drugs covered under another provision of the Agreement;
  - Prescription Drugs covered without charge under federal, state or local programs including Worker's Compensation and Occupational Disease laws;
  - Medication for a Member confined to a rest home, Skilled Nursing Facility, sanitarium, extended care facility, Hospital or similar entity;
  - Medication furnished by any other medical service for which no charge is made to the Member;
  - Any Covered Drug or Supply administered at the time and place of the Prescription Order;
  - Any charges for the administration of Prescription Legend Drugs or injectable insulin;
  - Prescription Drugs provided by Non-Participating Pharmacies, except as specified in Section RX - Prescription Drug Benefits;
  - Prescription Refills resulting from loss or theft, or any unauthorized Refills;
  - Immunization agents (except those covered on the Drug Formulary), biological sera, blood or plasma, or allergy serum;
  - Experimental or Investigational Drugs or drugs Prescribed for experimental (non-FDA approved) indications;
  - 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;
  - Injectables used for treatment of infertility when they are prescribed solely to enhance or facilitate conception;
  - 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;
  - Specialty Drugs that are not purchased through a pharmacy other than those specified in Section RX - Prescription Drug Benefits. This exclusion does not apply to Insulin;
  - Any charge where the usual and customary charge is less than the Member's cost-sharing amount;
  - For Convenience Pack drugs which combine two or more individual drug products into a single package with a unique national drug code;

- 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**:
  - Incurred prior to the Subscriber's Effective Date of Coverage or after the Termination Date of

coverage under the Individual Agreement.

- For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
- For prescription and non-prescription drugs, vitamins or dietary supplements.
- 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).
- Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
- 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.
- 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.
- For treatment of fractures and dislocations of the jaw.
- For treatment of malignancies or neoplasms.
- 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.
- For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
- For periodontal splinting of teeth by any method.
- For duplicate dentures, Prosthetic Devices or any other duplicative device.
- For which in the absence of insurance the Member would Incur no charge.
- For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
- For treatment and appliances for bruxism (night grinding of teeth).
- 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.
- 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).
- 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.
- For specialized procedures and techniques (for example, but not limited to, precision attachments, copings and intentional root canal treatment).
- Fees for broken appointments.
- 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.
- 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 in 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;

- For laboratory and pathology tests in connection with obtaining or continuing employment;

- Liposuction (suction-assisted lipectomy) for the treatment of lipedema;
  This exclusion does not apply to:
  - Liposuction (suction-assisted lipectomy) for the treatment of lipedema when the HMO:
    - Determines the liposuction (suction-assisted lipectomy) is Medically Necessary; and
    - The liposuction (suction-assisted lipectomy) is limited to one procedure per area of the body per lifetime;

- For services designated as intensive behavioral health services/pediatric intensive behavioral health services (defined in Pennsylvania Medical Assistance Manual Chapter 1155), except as specifically provided under this Program (For example, Home Health Care);

- Drugs, Biologics, and Gene Therapies That Have Not Received Final/Standard/Traditional FDA Approval.

  For drugs, biologics, or gene therapies, **with the exception of cancer treatments**, that receive an accelerated approval based on surrogate endpoints with the requirement by the FDA to perform confirmatory trials to demonstrate clinical benefits **and not** of a final, standard, traditional FDA approval **for a period of 18 months after the accelerated approval**.

  Monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease: e.g., aducanumab- avwa

  Delandistrogene moxeparvovec

  Tofersen

  Exon skipping drugs for Duchenne Muscular Dystrophy (DMD): e.g., Eteplirsen, Golodirsen, Viltolarsen, Casimersen

  Lecanemab-irmb (Leqembi)

- With regard to the Autism benefit, the following exclusions apply:
  - For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
  - For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

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 they are 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 their 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 an Appeal of an Administrative Denial or Medical Necessity Appeal may be commenced against the HMO until the Member has exhausted their 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.** However, if you are an individual enrolled in an On-Exchange product, receives a tax credit, and you previously paid at least one (1) month's premium during the Benefit Period, the grace period will be **three (3) consecutive months**. During the three (3) month period, the HMO will pay all appropriate claims during the first month of the grace period. However, the HMO may pend claims in the second and third months of the grace period and provide notification as such. 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. If premiums are not paid by the end of the applicable grace period, this Agreement automatically terminates, 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 Section SC - 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. **Blue Cross Blue Shield Global Core**

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 Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711). 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 Blue Cross Blue Shield Global Core 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 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. **Medical Necessity Appeals 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 Medical Necessity Appeal 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 Medical Necessity Appeal and Appeals section for a complete explanation of the process and procedure for filing a Medical Necessity Appeal or an appeal. When filing a Medical Necessity Appeal 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) through reductions in future premium costs to the Subscriber. Under some circumstances, the HMO may use a portion of the rebates received from its PBM to lower the drug price used for purposes of determining what the Member should pay based on Member benefits at the time a rebatable drug is dispensed to the Member at a Participating Pharmacy. 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

If any Premium is not paid within the Grace Period specified above, a subsequent acceptance of Premium by the HMO or by any agent duly authorized by the HMO to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Agreement. However, if the HMO requires an application for reinstatement and issues a conditional receipt for the Premium, the Agreement will be reinstated upon approval of such application by the HMO. Lacking such approval, the Agreement will be reinstated upon the forty-fifth (45th) day following the date of such conditional receipt unless the HMO has previously notified the Subscriber in writing of its disapproval of such application. The reinstated Agreement shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. The Subscriber and the HMO shall have the same rights thereunder as they had under the Agreement immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Note – If the Subscriber receives a premium tax credit the Subscriber is not eligible for reinstatement.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

Subscriber hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Subscriber and Keystone Health Plan East (Keystone), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and BlueShield Plans (the “Association”), permitting Keystone to use the Blue Cross Service Marks in a portion of the Commonwealth of Pennsylvania and that Keystone is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Keystone and that no person, entity, or organization other than Keystone shall be held accountable or liable to Subscriber for any of Keystone’s obligations to Subscriber created 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.

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, pre-existing conditions, health status, and marital status;
- 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.

Rights and Responsibilities

To obtain a list of Rights and Responsibilities, log onto https://www.ibx.com/quality-management#member, or the Member can call the Customer Service telephone number listed on their ID Card.

KEYSTONE HEALTH PLAN EAST, INC.

2027 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, other applicable laws and regulations or any other additions as determined by the HMO. 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 are 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 • Obesity Screening • Unhealthy drug use screening	One exam annually for all adults
SCREENINGS	
Abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males ages 65 to 75 years with a history of smoking
Prediabetes and Type 2 diabetes mellitus screening and intensive counseling interventions	Prediabetes and type 2 diabetes screening for adults ages 35 to 70 years who are overweight or obese Intensive behavioral counseling interventions for individuals ages 35 to 70 years who are overweight or obese with abnormal blood glucose up to 32 sessions per year
Anxiety Screening	All adults 64 years and younger
Colorectal cancer screening	Adults ages 45 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 • CT colonography: once every five years • Stool DNA testing: once every one to three years • Colonoscopy: once every 10 years

Depression and suicide risk 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
High blood pressure screening	Adults ages 18 years or older with increased risk once a year Adults ages 18 to 39 years with no other risk factors once every 3 to 5 years Adults age 40 years once a year
Human immunodeficiency virus (HIV) screening	All adults
Latent tuberculosis infection screening	Asymptomatic adults age 18 years or older at increased risk for tuberculosis
Lung cancer screening	Adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
Syphilis infection screening	All adults at increased risk for syphilis infection
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence Behavioral counseling in a primary care setting for individuals with a positive screening result
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Behavioral interventions for weight loss to prevent obesity-related morbidity and mortality	Behavioral intervention for adults with a body mass index (BMI) of 30 kg/m^2 or higher
Exercise interventions for the prevention of falls	Community-dwelling adults age 65 years and older with an increased risk of falls
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults with known cardiovascular disease risk factors
Tobacco use counseling	All adults who use tobacco products
Work-up and follow-up services for pre-exposure prophylaxis for the prevention of HIV	Adults at high risk for HIV infection

MEDICATIONS	
Pre-exposure prophylaxis for the prevention of HIV infection	Adults at high risk for HIV infection
Prescription bowel preparation	Adults ages 45 years and older when used in conjunction with a preventive colorectal cancer screening procedure (flexible sigmoidoscopy, colonoscopy, virtual colonoscopy)
Statin	Adults ages 40-75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10-year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

IMMUNIZATIONS

Ages 19 Years or Older

Vaccine	19-26 years	27-49 years	50-64 years	≥65 years
COVID-19	1 or more doses of 2025–2026 vaccine			≥ 2 doses of 2025-2026 vaccine
Influenza vaccine	1 dose annually			
Respiratory Syncytial Virus (RSV)	Seasonal administration during pregnancy.		50 through 74 years	≥75yrs
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management			
	1 dose Tdap, then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV)	2 doses for immunocompromising conditions		2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 - 45 years		
Pneumococcal (PCV15, PCV20, PCV21, PPSV23)				
Hepatitis A (HepA)	2, 3, or 4 doses depending on vaccine			
Hepatitis B (HepB)	2, 3, or 4 doses depending on vaccine or condition (19 – 59 years)			
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication			
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication			
	19 through 23 years			
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication			
Mpox	2 doses			
Inactivated poliovirus (IPV)	Complete 3-dose series if incompletely vaccinated.			

Legend

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of immunity	Recommended vaccination for adults with an additional risk factor or another indication	Recommended vaccination based on shared clinical decision-making	No Guidance/Not Applicable

The content of this immunization schedule is subject to change 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, other applicable laws and regulations, or any other additions as determined by the HMO.

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	
Prenatal Care Visits Services that may be provided during the prenatal care visits include, but are not limited to the following: • Screening for hypertensive disorders	All pregnant females
Postpartum Care Visit	All postpartum females
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 • Counseling for the prevention of obesity • Discussion of chemoprevention for breast cancer • Instruction on fertility awareness-based methods, including the lactation amenorrhea method • Intimate partner and domestic violence screening • Primary care interventions to promote and support breastfeeding • Recommended preventive preconception and prenatal care services • Urinary incontinence Screening	At least annually
SCREENINGS	
Anxiety Screening	All females
Bacteriuria screening	All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if first prenatal visit occurs later than 12 to 16 weeks gestation
Counseling interventions to prevent perinatal depression	Pregnant or postpartum females at increased risk for perinatal depression without a current diagnosis of depression 20 sessions over a 70-week period

BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic females with an ancestry associated with BRCA gene mutations, or with a personal or family history of a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling
Breast cancer screening (mammography with additional imaging (mammography, MRI or ultrasound) and pathology evaluation when needed)	Annually for all females ages 40 years and older Females under 40 years of age based on the provider's recommendation
Cervical cancer screening (Pap test/HPV testing) with additional testing (cytology, biopsy, colposcopy, extended genotyping, dual stain, and pathology evaluation when needed)	Ages 21 to 65: Every 3 years with Pap test Ages 30 to 65: Every 5 years with primary HPV testing or a combination of Pap test/HPV testing
Chlamydia and gonorrhea screening	Sexually active females ages 24 years and younger or older sexually active females who are at increased risk for infection
Diabetes screening after pregnancy	Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus
Depression and suicide risk screening	All pregnant and post-partum females
Gestational diabetes mellitus screening	Asymptomatic pregnant females after 24 weeks of gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes
Hepatitis B virus (HBV) screening	All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All pregnant females Individuals ages 15 years and older Individuals younger than age 15 years at increased risk for HIV infection
Osteoporosis (bone mineral density) screening	Every 2 years for females younger than age 65 years who are at increased risk for osteoporosis Every 2 years for females age 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition
RhD incompatibility screening	All pregnant females and follow-up testing for females at higher risk
Syphilis screening	All pregnant females at first prenatal visit For high-risk pregnant females, repeat testing in the third trimester and at delivery Individuals at increased risk for syphilis infection
Tobacco use counseling	All pregnant females who smoke tobacco products

Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all pregnant females Behavioral counseling in a primary care setting with a positive screening result
MEDICATIONS	
Breast cancer chemoprevention	Asymptomatic females ages 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 females planning for or capable of pregnancy
Low-dose aspirin	Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation
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 females with reproductive capacity
Patient navigation services for breast and cervical cancer screening	Adults who are eligible for breast or cervical cancer screening

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pediatric prenatal exams	All expectant parents for the purpose of establishing a relationship with the pediatrician
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 • High body mass screening • Oral health risk assessment • Risk assessment of sudden cardiac arrest and sudden cardiac death	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 screening and behavioral counseling intervention	Annually for all children ages 11 years and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
Anxiety screening	For children 8 years and older
Autism and developmental screening	All children
Behavioral/social/emotional screening	All children
Bilirubin screening	All newborns
Chlamydia and gonorrhea screening	All sexually active individuals up to age 21 years
Depression and suicide risk screening	Annually for all children ages 12 years to 21 years
Dyslipidemia screening	Following a positive risk assessment or in children where laboratory testing is indicated
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
Iron deficiency anemia screening	All children
Lead poisoning screening	All children at risk of lead exposure
Newborn screening panel (for example, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	All newborns
Syphilis screening	All sexually active individuals up to age 21 years
Vision 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
High body mass screening and behavioral counseling	Screening is part of the preventive exam for children ages 6 years and older. Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater
MEDICATIONS	
Fluoride	Oral fluoride for children ages 6 months to 16 years whose water supply is deficient in fluoride
Prophylactic ocular topical medication for gonorrhea	All newborns within 24 hours after birth
MISCELLANEOUS	
Fluoride varnish application	Every 3 months for all infants and children starting at age of primary tooth eruption to age 5 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)

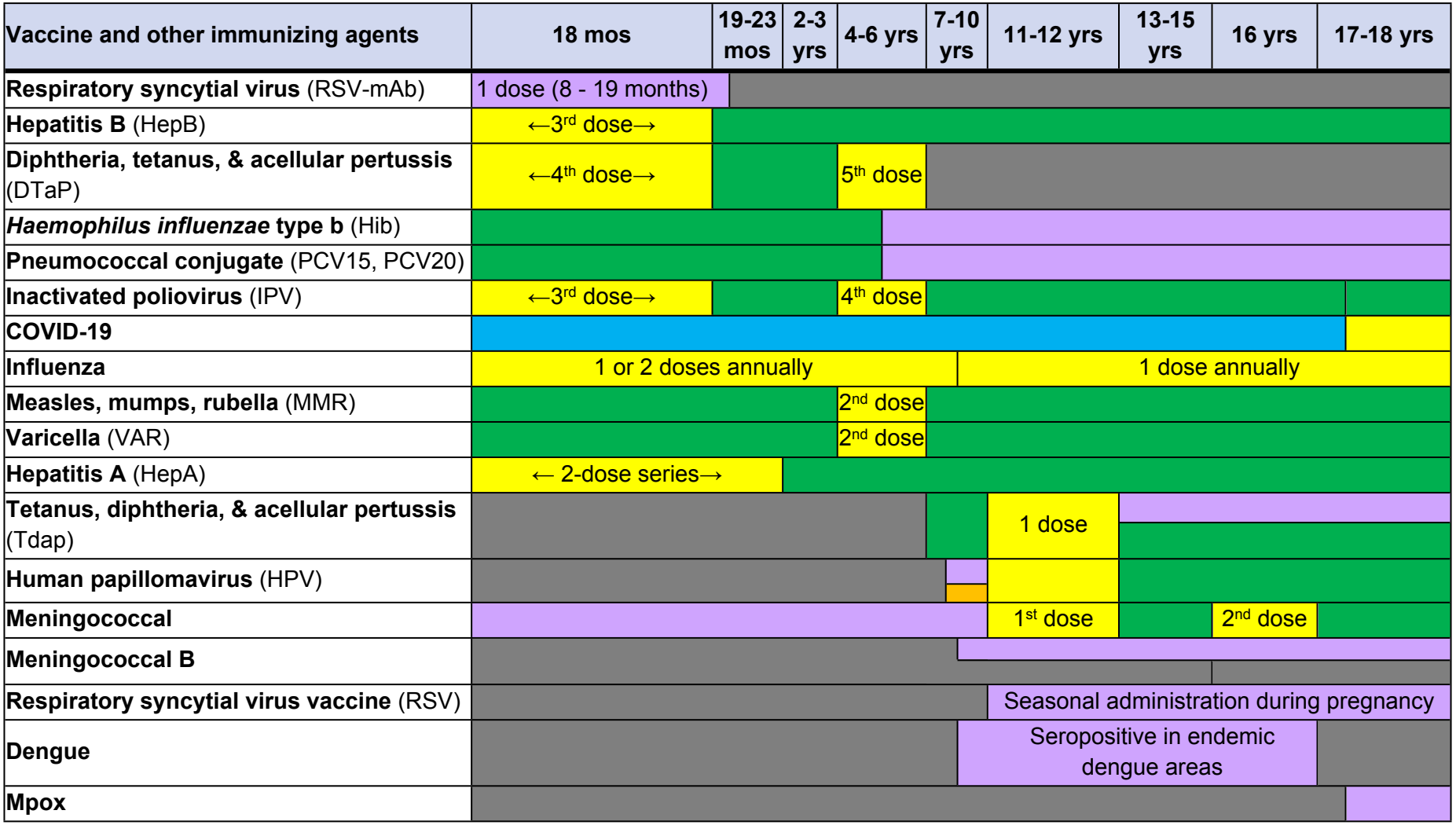
Birth to 15 Months

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos
Respiratory syncytial virus (RSV-mAb)	1 dose depending on maternal RSV vaccination status				1 dose (8 through 19 months),			
Hepatitis B (HepB)	1st dose	←2nd dose→			←3rd dose→			
Rotavirus (RV)			1st dose	2nd dose				
Diphtheria, Tetanus, & acellular pertussis (DTaP)			1st dose	2nd dose	3rd dose			←4th dose→
***Haemophilus influenzae* type b** (Hib)			1st dose	2nd dose			←3rd or 4th dose,	
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose		←4th dose→	
Inactivated poliovirus (IPV)			1st dose	2nd dose	←3rd dose→			
COVID-19					1 or more doses of 2025–2026 vaccine (6 months to 2 years)			
Influenza					1 or 2 doses annually			
Measles, mumps, rubella (MMR)							←1st dose→	
Varicella (VAR)							←1st dose→	
Hepatitis A (HepA)							←2-dose series,	
Meningococcal								

Legend

Range of recommended ages for all children	Range of recommended ages for catch-up vaccination	Range of recommended ages for certain high-risk groups or populations	Vaccination is based on shared clinical decision making	No Guidance/Not Applicable

18 Months to 18 Years



Legend

Range of recommended ages for all children	Range of recommended ages for catch-up vaccination	Range of recommended ages for certain high-risk groups or populations	Recommended vaccination can begin in this age group	Vaccination is based on shared clinical decision making	No Guidance/Not Applicable

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PREV/SCH-II Rev. 1.27

Independence

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] ("Independence") 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.

The definition of PHI also includes race, ethnicity, language, gender identity and sexual orientation information transmitted or maintained in any form or medium by Independence.[3]

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

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[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, Independence Assurance Company, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc. – independent licensees of the Blue Cross and Blue Shield Association.

[3] Independence Blue Cross does not use race, ethnicity, language, gender identity and sexual orientation information for underwriting, rate setting, denial of services, coverage or benefits determinations.

certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

This revised Notice took effect on February 1, 2026, 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 use disorder, and genetic testing.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes/substance use disorder information about you, selling your health information to others, or using or disclosing your health information for certain prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may revoke your written authorization at any time in writing, except if we have already acted based on your authorization.

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 disclose 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 certain Health Oversight Activities described below.

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

Substance Use Disorder Information: We are not a substance use disorder treatment program, though we may receive or maintain information about you from a substance use disorder program. If a substance use disorder program provides us with this information by

way of a 42 CFR Part 2 consent, including a consent for future uses and disclosures for treatment, payment, and health care operations, we will use or share that information in accordance with your consent, HIPAA, and applicable law. We may use and share substance use disorder records without your consent for the following purposes, when all conditions required by state and federal law are met: medical emergencies, scientific research, management audits, financial audits, program evaluation, and disclosures to public health authorities when the health records are de-identified. In addition, we cannot use or disclose information about a member's treatment for substance use disorders (or provide testimony based on such information) for any civil, criminal, administrative, or legislative proceedings against the member. Any such disclosure is permitted only with the member's consent or a special type of court order, for which the member must have notice and an opportunity to object, as well as a subpoena, court order, or similar legal mandate.

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.

Online Tracking Technology: We use online tracking technologies to analyze website traffic and improve our website's functionality. These technologies may collect your IP address, browser type, and other information about your browsing behavior. We may share this information with third-party analytics vendors to help us understand how people use our website and to improve our services. You can opt out of some tracking technologies by adjusting your browser settings.

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 and 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.

Health Information Exchanges

We share your health information electronically through certain Health Information Exchanges ("HIEs"). A HIE is a secure electronic data sharing network. In accordance with applicable federal and state privacy and security requirements, regional health care providers participate in HIEs to exchange patient information in real-time to help facilitate delivery of health care, avoid duplication of services, and more efficiently coordinate care. As a participant in HIEs, Independence shares your health information we may have received when a claim has been submitted for services you have received among authorized participating providers, such as physicians, hospitals, and health systems for the purpose of treatment, payment and health care operations as permitted by law.

During an emergency, patients and their families may forget critical portions of their medical history which may be very important to the treating physician who is trying to make a quick, accurate diagnosis in order to treat the sick patient. Independence, through its participation

in an HIE, makes pertinent medical history, including diagnoses, studies, lab results, medications and the treating physicians we may receive on a claim available to participating emergency room physicians while the patient is receiving care. This is invaluable to the physician, expediting the diagnosis and proper treatment of the patient.

Your treating providers who participate with an HIE, and also submit health information with the HIE, will have the ability to access your health information through the HIE and send records to your treating physicians. Through direct requests to the HIE, we will receive various types of protected health information such as pharmacy or laboratory services, or information when you have been discharged from a hospital which may be used to coordinate your care, provide case management services, or otherwise reduce duplicative services and improve the overall quality of care to our members. All providers that participate in HIEs agree to comply with certain privacy and security standards relating to their use and disclosure of the health information available through the HIE.

As an Independence member, you have the right to opt-out which means your health information will not be accessible through the HIE. Through the regional HIE (https://healthshareexchange.org/patient-options-opt-out-back/) website or the State HIE (https://www.pa.gov/agencies/dhs/resources/for-residents/ehealth-citizens.html) website consumers or providers can access an online, fax, or mail form permitting patients to remove themselves (opt-out) or reinstate themselves (opt back in) to the HIE. It will take approximately one business day to process an opt-out request. If you choose to opt-out of the HIE, your health care providers will not be able to access your information through the HIE. Even if you opt-out, this will not prevent your health information from being made available and released through other means (i.e. fax, secure email) to authorized individuals, such as network providers for paying claims, coordinating care, or administering your health benefits in accordance with the law and in the normal course of conducting our business as permitted under applicable law. For more information on HIEs, please go to https://healthshareexchange.org/consumers/ or to https://www.pa.gov/agencies/dhs/resources/for-residents/ehealth-citizens.html.

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"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will **not** include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- 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 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 member 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)

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual annuities:

- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.

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Independence

Independence Blue Cross offers products through its subsidiaries and affiliates including Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

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