Independence

Personal Choice®



BENEFITS BOOK

How your health plan works
PPO

IBX
Never stop caring

Table of Contents

Welcome to Independence Blue Cross 4
Introduction 5
Using Your Benefits to Receive Care 6
Where to Go for Care 7
You're Covered While Traveling 8
Manage Your Benefits Online 9
Healthy Savings/Connect with Us/Member Support 10
Using Your Prescription Drug Benefits 11
Mail Order/Home Delivery 13
Using Your Vision Benefits 15
OUTLINE OF COVERAGE 16
SCHEDULE OF BENEFITS 19
INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL PREFERRED PROVIDER POLICY (PERSONAL CHOICE®) 51
SECTION DE - DEFINITIONS 61
SCHEDULE OF BENEFITS 84
SECTION DB – DESCRIPTION OF BENEFITS 109
- Primary and Preventive Care 110
- Inpatient Benefits 112
- Inpatient/Outpatient Benefits 114
- Outpatient Benefits 120

SECTION EX - EXCLUSIONS 140
SECTION GP – GENERAL PROVISIONS 146
- Entire Contract; Changes 146
- Time Limit on Certain Defenses 146
- Grace Period 146
- Reinstatement 146
- Legal Actions 146
- Effective Date and Term 146
- Benefits to Which Covered Persons are Entitled 147
- Termination of the Contract 147
- Change in Status and Charges 147
- Benefits After Termination of Coverage 149
- Release of Information 150
- Covered Person/Provider Relationship 150
- Identification Cards 150
- Applicable Law 150
- Notice 150
- Coordination of Benefits 150
- Subrogation and Reimbursement Rights 152
- Payment of Providers 153
- BlueCard® Program 160
- Limitations of Carrier Liability 162
- Right to Enforce Contract Provisions 162
- Special Circumstances 163
- Premium Rates 163
- Disclosure 163
- Discounts and Wellness/Reward Incentives Programs 163
- Identity Protection Services 164

SECTION CL - CLAIMS 165
- Notice of Claim 165
- Furnishing Claim Forms 165
- Proofs of Loss 165

Time of Payment of Claims **165**
Physical Examination and Autopsy **165**
Payment of Claims **165**
Right to Recover Payments in Error **165**
SECTION MC – MANAGED CARE **166**
Utilization Review Process **166**
Clinical Criteria, Guidelines and Resources **167**
Delegation of Utilization Review Activities and Criteria **167**
Disease Management and Decision Support Programs **168**
Precertification Review **168**
Other Precertification Requirements **171**
Out-of-Area Care for Dependent Students **172**
SECTION MR – YOUR MEMBERSHIP RIGHTS AND RESPONSIBILITIES **173**
SECTION RS – RESOLVING PROBLEMS **174**
Complaint Process **174**
Appeal Process **174**
PREVENTIVE SCHEDULE **184**

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:

- 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

You have a Personal Choice® PPO health plan, which means you have the freedom to see any in- or out-of-network doctor or specialist without a referral. You will receive the highest level of benefits when you receive care through our provider network.

It's a smart idea to select a primary care physician (PCP), even though your health plan doesn't require you to. A PCP can help you stay healthy by providing regular checkups and coordinating your care.

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.

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).

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.

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.

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

You also have in-network coverage across the U.S. through BlueCard® PPO, which offers the largest network of doctors and hospitals in the country.

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.

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.

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.

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. 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 with BlueCard® PPO

You can travel with peace of mind, knowing that Blue goes with you wherever you go. With BlueCard PPO, you can present your ID card to any provider in the Blue Cross® and/or Blue Shield® PPO network across the country, and your costs are the same as if you were being treated by an in-network, local provider.

If you have a medical emergency when you are far away from home, you have two options:

- In a true emergency, go to the nearest ER.
- In an urgent care situation, find a BlueCard provider in the area.

Call 1-800-810-BLUE (1-800-810-2583; TTY: 711) or visit bcbs.com to find a BlueCard provider in your area.

You can 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 the ER.

Out of town and need care?

Call **1-800-810-BLUE (1-800-810-2583; TTY: 711)** or visit **bcbs.com** 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
- Create a custom directory of your doctors
- Estimate what you will pay for an office visit or procedure based on your benefits

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 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 COMPREHENSIVE MAJOR MEDICAL
PREFERRED PROVIDER POLICY
(PERSONAL CHOICE®)
issued by

QCC INSURANCE COMPANY*
(Called the Carrier)

***a subsidiary of Independence Blue Cross - an independent licensee of the Blue Cross and Blue Shield Association.**

A Pennsylvania corporation
Located at:
1901 Market Street
Philadelphia, PA 19103

NOTICE OF COVERED PERSON'S RIGHT TO EXAMINE CONTRACT: The Applicant has a right to return the Contract within ten (10) days of delivery for refund of the full premium paid if, after examination of the Contract, the Applicant is not satisfied for any reason. The Contract may be returned to: QCC Insurance Company, 1901 Market Street, Philadelphia, PA 19103. If the Contract 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 Contract carefully.** This outline provides a very brief description of the important features of the Contract. This outline is not the insurance contract and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both the Applicant and the Carrier. It is, therefore, important to read the Contract carefully!

2. **Comprehensive Major Medical Expense Coverage.** The Contract is a health policy that provides, to Covered Persons, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to the Deductibles and Coinsurance provisions. This Comprehensive Major Medical Contract is marketed by the Carrier as a Preferred Provider Organization benefit program that utilizes a Preferred Provider Network to maximize benefits while offering Covered Persons the choice of selecting Non-Preferred Providers, except where specifically prohibited by the Contract, subject to a reduction of benefits. The Contract utilizes extensive Precertification and utilization management procedures which must be followed to maximize benefits and avoid penalties. Failure to obtain Precertification for services provided by a BlueCard Provider or an out-of-network (Non-Preferred) Provider will result in a 50% reduction in benefits. This coverage does not supplement any basic hospital or basic medical insurance coverage.

THIS IS A NON-PARTICIPATING CONTRACT

3. **A brief description of the benefits contained in the Contract is as follows:**
Subject to the ***Exclusions***, conditions and limitations of the Contract, a Covered Person is entitled to benefits for Covered Services and Covered Expenses described in this section during a Benefit Period, subject to the Deductible, Coinsurance, Copayment and Benefit Maximum amounts as specified below. With the exception of Emergency Care Services, which are paid at the Preferred (In-Network) level of benefits, regardless of whether the Provider was a Preferred or Non-Preferred (Out-of-Network) Provider, benefits payable for Covered Services which are not provided by a Preferred Provider, are subject to the application of a higher Coinsurance level and Deductible amount as described below:

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

COVERED EXPENSE - refers to the basis on which a Covered Person's Deductibles, Coinsurance, and benefits are calculated.

A. For Covered Services provided by a Facility Provider, the term "Covered Expense" means the following:
    1. For Covered Services provided by a Preferred Facility Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier.
    2. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.
    3. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by the applicable Carrier's proprietary fee schedule for the closest analogous Covered Service.

B. For Covered Services provided by a Professional Provider, Covered Expense means the following:
    1. For Covered Services by a Preferred Professional Provider or BlueCard Provider, "Covered Expense" means the rate of reimbursement for Covered Services the Professional Provider has agreed to accept as set forth by contract with the Carrier, or the BlueCard Provider.
    2. For Covered Services by a Non-Preferred Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider's charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:
    1. For Covered Services provided by a Preferred Ancillary Provider or BlueCard Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or BlueCard Provider.
    2. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Non-Preferred Ancillary Provider's charges for Covered Services.
D. For Prescription Drugs provided by Pharmacies, Covered Expense means the following:
    1. For Prescription Drugs provided by a Preferred Pharmacy, Covered Expense means the amount that the Carrier has negotiated with the Carrier's Pharmacy Benefits Manager as total reimbursement for the covered Prescription Drugs.
    2. For Prescription Drugs provided by a Non-Preferred Pharmacy, Covered Expense means the Pharmacy's charges for the covered Prescription Drugs.
E. For Pediatric Dental Covered Services provided by a Participating Dentist, Covered Expense 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.
F. Nothing in this section shall be construed to mean that the Carrier would provide coverage for services other than Covered Services.

OUT-OF-POCKET LIMIT - a specified dollar amount of Coinsurance, Deductible and Copayment expense Incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include charges which are in excess of the Carrier's total payment for Covered Services whether those services are performed by a Preferred or Non-Preferred Provider or charges for Covered Services that are not Essential Health Benefits. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the ***Schedule of Benefits*** of this Contract.

SCHEDULE OF BENEFITS

Subject to the ***Exclusions***, conditions and limitations of this Contract, a Covered Person is entitled to benefits for Covered Services and Covered Expenses described in this section during a Benefit Period, subject to the Deductible, Coinsurance, Copayment and Benefit Maximum amounts as specified below. With the exception of Emergency Care Services, which are paid at the Preferred (In-Network) level of benefits, regardless of whether the Provider was a Preferred or Non-Preferred (Out-of-Network) Provider, benefits payable for Covered Services which are not provided by a Preferred (In-Network) Provider, are subject to the application of a higher Coinsurance level and Deductible amount as described below:

The percentages for your Coinsurance and Covered Services shown below are not always calculated on actual charges. For an explanation on how coinsurance is calculated, see the "Covered Expense" definition in the ***Definitions*** section of this Contract.

BENEFIT PERIOD	Calendar Year (1/1 - 12/31)
PROGRAM DEDUCTIBLE ***(Covered Person's Responsibility)***	
Covered Person's Deductible ***(Single Coverage)***	
Preferred Care	None.
Non-Preferred Care	$6,000 per Covered Person per Benefit Period for Non-Preferred Covered Services. This Deductible applies to all Non-Preferred Covered Services except as otherwise specified.
Family Deductible ***(Family Coverage)***	
Preferred Care	None.

Family Deductible ***(Family Coverage)*** **(Continued)**	
Non-Preferred Care	The family Deductible amount is equal to two (2) times the individual Deductible in each Benefit Period for Non-Preferred Covered Services, it will be applied for all family members covered under a Family Coverage. A Deductible will not be applied to any covered individual family member once that covered individual has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.
Deductible Carryover	Expenses Incurred for Covered Expenses in the last three (3) months of the initial Benefit Period which were applied to that Benefit Period's Deductible will be applied to the Deductible of the next Benefit Period. This only applies to Covered Persons who enroll in the fourth quarter of the initial Benefit Period.
COINSURANCE ***(Covered Person's Responsibility)***	
Preferred Care	20% for most Preferred Covered Services, except as otherwise specified in the ***Schedule of Benefits***.
Non-Preferred Care	50% for most Non-Preferred Covered Services, except as otherwise specified in the ***Schedule of Benefits***.
OUT-OF-POCKET LIMIT	
INDIVIDUAL OUT-OF-POCKET LIMIT ***(Single Coverage)***	
Preferred Care	When a Covered Person Incurs $8,750 of Copayment and Coinsurance expense for Essential Health Benefits in one Benefit Period for Preferred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of the Benefit Period. The dollar amounts specified shall not include any expense Incurred for a Penalty amount.
Non-Preferred Care	When a Covered Person Incurs $12,000 of Coinsurance and Deductible expense in one Benefit Period for Non-Preferred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. The dollar amounts specified shall not include any expense Incurred for a Penalty amount.

OUT-OF-POCKET LIMIT (Continued)	
FAMILY OUT-OF-POCKET LIMIT *(Family Coverage)*	
Preferred Care	After two (2) times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage for Essential Health Benefits in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount.
Non-Preferred Care	After two (2) times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount.
LIFETIME MAXIMUM	
Preferred Care	Unlimited.
Non-Preferred Care	Unlimited.

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
OFFICE VISITS/RETAIL CLINICS/TELEMEDICINE VISITS*		
Office Visits/Retail Clinics	100%, after a Copayment of $30 per Provider per date of service.	50%
Telemedicine Visits (excluding Retail Clinics)	100%, after a Copayment of $20 per Provider per date of service.	50%
*If a Covered Person receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.		
PEDIATRIC PREVENTIVE CARE Deductible does not apply.	100%	50%
IMMUNIZATIONS Deductible does not apply.	100%	50%
ADULT PREVENTIVE CARE Deductible does not apply.	100%	50%
PREVENTIVE COLONOSCOPY Deductible does not apply.		
Preventive Plus (P+) Facility/Non-Hospital Based Facility*	100%	50%

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Non-Preventive Plus (P+) Facility/Hospital Based Facility * For $0 (100%) Covered Person cost-sharing to apply, all services must be performed by a Preferred gastroenterologist or a colon and rectal surgeon. ** The Copayment will be waived if the Preferred Provider determines that it is Medically Necessary to have the service performed by a Provider that is Hospital based. There is no cost-share applied if the preventive colonoscopy service is performed at a facility that is not Hospital based (i.e., an Ambulatory Surgical Facility); if the 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 (P+) Providers, colonoscopy screenings must meet the United State Preventive Services Task Force's (USPSTF) guidelines for $0 (100%) Covered Person cost-sharing to apply.	100%, after a Copayment of $750 per Provider per date of service**.	50%

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
SMOKING CESSATION Deductible does not apply.	100%	50%
WOMEN'S PREVENTIVE CARE Deductible does not apply.	100%	50%
ROUTINE GYNECOLOGICAL EXAMINATION, PAP SMEAR One (1) examination per Benefit Period. Deductible does not apply.	100%	50%
MAMMOGRAMS Deductible does not apply.	100%	50%
NUTRITION COUNSELING Maximum of six (6) Preferred/Non-Preferred visits per Benefit Period. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%	50%

INPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
HOSPITAL SERVICES * In the event of a Non-Preferred Inpatient Emergency admission, all benefits will be provided at the Preferred level of benefits; and the out of pocket expense will be no higher than if services were provided by a Preferred Provider.	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50%* Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
MEDICAL CARE Cost-sharing does not apply to physician/surgeon fees (including Inpatient anesthesia) that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80%	50%
SKILLED NURSING CARE FACILITY Maximum of 120 Preferred/Non-Preferred Inpatient days per Benefit Period. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $375 per day, to a maximum of $1,875, per admission.	50%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
BLOOD Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80%	50%
HOSPICE SERVICES Respite Care: Maximum of seven (7) Preferred/Non-Preferred days every six (6) months. Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%	50%
MATERNITY/OB-GYN/FAMILY SERVICES		
Maternity/Obstetrical Care		
Professional services	100%, after a Single Copayment of $65	50%
Facility services: Inpatient/Birthing Center	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission.	50%
Elective Abortions		
Professional services	100%, after a Copayment of $65 per procedure.	50%
Outpatient Facility services		
Ambulatory Surgical Facility	100%, after a $300 Copayment per procedure.	50%
Hospital based	100%, after a $700 Copayment per procedure.	50%
Newborn Care * There is no cost-share applied for Gonorrhea eye drops for newborns. Cost-sharing does not apply for the first thirty-one (31) days following birth.	100%*	50%
Artificial Insemination	100%, after a Copayment of $65 per procedure.	50%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
SURGICAL SERVICES		
Ambulatory Surgical Facility	100%, after a $300 Copayment per day.	50%
Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Hospital based	100%, after a $700 Copayment per day.	50%
Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Outpatient Professional Charge	80%	50%
Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Outpatient Anesthesia	80%	50%
Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Second Surgical Opinion		
Office Visits	100%, after a Copayment of $65 per service/occurrence.	50%
Telemedicine Visits	100%, after a Copayment of $45 per service/occurrence.	50%
If more than one (1) surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.		

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
MENTAL HEALTH/PSYCHIATRIC CARE		
Inpatient Treatment	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
Outpatient Treatment		
Office Visit	100%, after a Copayment of $65 per Provider per date of service.	50%
All Other	100%, after a Copayment of $65 per Provider per date of service.	50%
Telebehavioral Health	100%	50%
TRANSPLANT SERVICES		
Inpatient Facility Charges	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission.	50%
Outpatient Facility Charges	100%, after a $300 Copayment per procedure.	50%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
TREATMENT OF ALCOHOL OR DRUG ABUSE AND DEPENDENCY		
Inpatient Hospital Detoxification and Rehabilitation	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
Hospital and Non-Hospital Residential Care	100 %, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
Outpatient Treatment		
Office Visit	100%, after a Copayment of $65 per Provider per date of service.	50%
All Other	100%, after a Copayment of $65 per Provider per date of service.	50%
Telebehavioral Health	100%	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
AMBULANCE SERVICES/TRANSPORT **Emergency** Deductible does not apply. **Non-emergency** * The Covered Person's out of pocket expense for emergency services will be no higher than if services were provided by a Preferred Provider.	100%, after a Copayment of $100. 100%, after a Copayment of $150.	100%, after a Copayment of $100.* 50%
AUTISM SPECTRUM DISORDERS Benefit Period Maximums and visit limits do not apply.	For services that are prescribed for Autism Spectrum Disorders, the cost-sharing will be the lesser of the applicable Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the medical service cost-share.	For services that are prescribed for Autism Spectrum Disorders, the cost-sharing will be the lesser of the applicable Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the medical service cost-share.
DAY REHABILITATION PROGRAM Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions. Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80% per service/occurrence.	50%
DIABETIC EDUCATION PROGRAM	100%	0% Benefits for Non-Preferred services are not available.
DIABETIC EQUIPMENT AND SUPPLIES	50%	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
DIAGNOSTIC SERVICES		
Routine Diagnostic/Radiology Services (including Allergy Testing)		
Freestanding	100%, after a Copayment of $60 per visit.	50%
Hospital Based	100%, after a Copayment of $90 per visit.	50%
Non-Routine Diagnostic/Radiology Services (including MRI/MRA, CT scans, PET scans and Nuclear Cardiology Imaging.)		
Freestanding	100%, after a Copayment of $120 per visit.	50%
Hospital Based	100%, after a Copayment of $160 per visit.	50%
Sleep Studies		
Home/Freestanding Sleep Center	100%, after a $300 Copayment per visit.	50%
Hospital Based	100%, after a $700 Copayment per visit.	50%
Laboratory and Pathology Tests		
Freestanding Laboratory	100%, after a $10 Copayment per visit.	50%
Hospital based Laboratory	100%, after a $85 Copayment per visit.	50%
DURABLE MEDICAL EQUIPMENT AND CONSUMABLE MEDICAL SUPPLIES, PROSTHETICS, ORTHOTICS	50%	50%
Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
EMERGENCY CARE SERVICES Deductible does not apply. * The Covered Person's out of pocket expense will be no higher than if services were provided by a Preferred Provider.	100%, after a Copayment of $400 per service/occurrence. (waived if admitted)	100%, after a Copayment of $400 per service/occurrence.* (waived if admitted)
HABILITATIVE THERAPY SERVICES		
Physical Therapy/Occupational Therapy		
Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions of Physical Therapy/Occupational Therapy combined. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Physical Therapy/Occupational Therapy cost-share.		
Freestanding	100%, after a Copayment of $65 per Provider per date of service.	50%
Hospital Based	100%, after a Copayment of $95 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Speech Therapy Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Speech Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
HOME HEALTH CARE First maternity home health care visit within forty-eight (48) hours of early discharge is exempt from Coinsurance amounts. Benefit Period Maximum: Sixty (60) Preferred/Non-Preferred sessions. Benefit Period Maximum and cost-sharing do not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	$150 Copayment per visit	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
INJECTABLE MEDICATIONS		
Specialty Drugs Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Home/Office	100%, after a Copayment of $120 per visit.	50%
Outpatient	100%, after a Copayment of $240 per visit.	50%
Standard Injectable Drugs	100%, after a Copayment of $60 per visit.	50%
The cost-sharing amounts for injected or infused drugs set forth above are applicable to those injected or infused drugs administered to a Covered Person who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Covered Person does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Covered Person will not accrue toward the satisfaction of the Covered Person's Program Deductible or Out-of-Pocket Limit. Additionally, the Carrier may elect to implement a program whereby each separate injected or infused drug will be paid by the Carrier 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 Covered Person will not result in a Covered Person paying more cost-sharing out of pocket for an injected or infused drug than they would have paid absent the Carrier's application of the program. Covered Persons 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.		
MEDICAL FOODS AND NUTRITIONAL FORMULAS Deductible does not apply.	80%	50%
METHADONE TREATMENT	100%	50%
NON-SURGICAL DENTAL SERVICES	80%	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
PRESCRIPTION DRUGS Deductibles do not apply.		
Retail Pharmacy *** Low-Cost Generic Drugs will be covered at 100%, after a $3 Copayment**	100%, after a Copayment of $20 for Generic Drugs*, and $100 Copayment for Preferred Brand and 50% for Non-Preferred Drugs, up to a Maximum of a $200 amount per prescription or refill.	30%
Specialty Drug Prescription or refill of 1-30 day supply**	50%, or 100% after Covered Person paying 50% reaches Maximum of $1,000 per prescription or refill.	Not Covered
Mail Order Pharmacy† Prescription or refill of 31-90 day supply *** Low-Cost Generic Drugs will be covered at 100%, after a $7.50 Copayment**	100%, after a Copayment of $50 for Generic Drugs*, and $250 Copayment for Preferred Brand and 50% for Non-Preferred Drugs, up to a Maximum of a $500 amount per prescription or refill.	Not Covered
Contraceptives, mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained from a Preferred Pharmacy or Preferred Mail Order Pharmacy for certain generic products and brand products. All other contraceptive products are covered at standard cost-sharing as reflected in this *Schedule of Benefits*.		

** 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 Covered Person who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Covered Person does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Covered Person will not accrue toward the satisfaction of the Covered Person's Program Deductible or Out-of-Pocket Limit. Additionally, the Carrier may elect to implement a program whereby each separate Prescription Order or refill for the Prescription Drug will be paid by the Carrier subject to the Covered Person's Coinsurance of 30%. This 30% Coinsurance associated with a Specialty Drug prescription or for certain other high-cost Prescription Drugs experienced by a Covered Person will not result in a Covered Person paying more cost-sharing out of pocket for a Prescription Drug or refill than they would have paid absent the Carrier's application of the program. Covered Persons 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 drugs to treat chronic conditions are available at the mail order Pharmacy and a designated retail Pharmacy.

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
REHABILITATIVE THERAPY SERVICES **Physical Therapy/Occupational Therapy** Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions of Physical Therapy/Occupational Therapy combined. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Physical Therapy/Occupational Therapy cost-share.		
Freestanding	100%, after a Copayment of $65 per Provider per date of service.	50%
Hospital Based	100%, after a Copayment of $95 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Speech Therapy Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Speech Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
SPECIALIST OFFICE/TELEMEDICINE VISITS*		
Office Visits	100%, after a Copayment of $65 per Provider per date of service.	50%
Telemedicine Visits	100%, after a Copayment of $45 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
SPINAL MANIPULATIONS Benefit Period Maximum: Twenty (20) Preferred/Non-Preferred sessions. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Spinal Manipulations cost-share.	100%, after a Copayment of $50 per Provider per date of service.	50%
THERAPY SERVICES **Cardiac Rehabilitation Therapy** Benefit Period Maximum: Thirty-six (36) Preferred/Non-Preferred sessions. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Cardiac Rehabilitation Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
Chemotherapy Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $65 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Dialysis Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $65 per Provider per date of service.	50%
Infusion Therapy Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Home/Office	100%, after a Copayment of $65 per Provider per date of service.	50%
Outpatient	100%, after a Copayment of $130 per Provider per date of service.	50%
Pulmonary Rehabilitation Therapy Benefit Period Maximum: Thirty-six (36) Preferred/Non-Preferred sessions. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Pulmonary Rehabilitation Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Radiation Therapy Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $65 per Provider per date of service.	50%
Respiratory Therapy For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Respiratory Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
URGENT CARE CENTER	100%, after a Copayment of $65 per Provider per date of service.	50%

OUTPATIENT BENEFITS *(Continued)*	If the Covered Person utilizes a contracted vendor, the Carrier will pay:	If the Covered Person does not utilize a contracted vendor, the Carrier will pay:
VIRTUAL CARE SERVICES (Vendor/Virtual Provider)		
Telemedicine Visit	100%	Not Covered
Teledermatology	100%	Not Covered
Telebehavioral Health	100%	Not Covered

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Preferred Provider, the Carrier will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:**
VISION CARE (PEDIATRIC)		
Routine Eye Exams and Refractions	100%	Benefits for Non-Preferred services are not available.
Eyeglasses, including Spectacle Lenses and Frames	100%	Benefits for Non-Preferred services are not available.
Elective Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses		
Davis Collection	100%	Benefits for Non-Preferred services are not available.
Non-Collection	100%, up to a maximum of $150 towards purchase and a 15% discount off balance over the $150 maximum, not available at all Preferred Providers	Benefits for Non-Preferred services are not available.
Elective Contact Lenses Fitting and Follow-up Care		
Standard Lenses	100%	Benefits for Non-Preferred services are not available.
Disposable/Specialty Lenses	100%, up to a maximum of $60 towards purchase and a 15% discount off balance over the $60 maximum, not available at all Preferred Providers	Benefits for Non-Preferred services are not available.
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including standard, specialty and disposable lenses	100%	Benefits for Non-Preferred services are not available.

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Participating Dentist, the Carrier will pay:**	**If the Covered Person uses a Non-Participating Dentist, the Carrier will pay:**
PEDIATRIC DENTAL SERVICES **Dental Deductible: $50 per eligible Covered Person must be met before applicable coinsurance amounts are applied. The Program Deductible does not apply.**		
Service Categories		
Oral Evaluations (Exams)	100% Dental deductible does not apply.	0%
Radiographs (All X-Rays)	50% Dental deductible does not apply.	0%
Prophylaxis (Cleanings)	100% Dental deductible does not apply.	0%
Fluoride Treatments	100% Dental deductible does not apply.	0%
Palliative Treatment (Emergency)	50% Dental deductible does not apply.	0%
Sealants	100% Dental deductible does not apply.	0%

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Participating Dentist, the Carrier will pay:**	**If the Covered Person uses a Non-Participating Dentist, the Carrier will pay:**
PEDIATRIC DENTAL SERVICES		
Service Categories (Continued)		
Teledentistry, synchronous or asynchronous	100% Dental deductible does not apply.	0%
Other Diagnostic & Preventive Services	Not Covered	0%
Space Maintainers	50%	0%
Amalgam Restorations (Metal fillings)	50%	0%
Resin-based Composite Restorations (White fillings)	50%	0%
Crowns, Inlays, Onlays	50%	0%
Crown Repair	50%	0%
Endodontic Therapy (Root canals, etc.)	50%	0%
Other Endodontic Services	50%	0%
Surgical Periodontics	50%	0%
Non-Surgical Periodontics	50%	0%
Periodontal Maintenance	50%	0%
Prosthetics (Complete or Fixed Partial Dentures)	50%	0%
Adjustments and Repairs of Prosthetics	50%	0%
Other Prosthetic Services	50%	0%
Maxillofacial Prosthetics	Not Covered	0%
Implant Services	50%	0%
Simple Extractions	50%	0%
Surgical Extractions	50%	0%
Oral Surgery	50%	0%
General Anesthesia, Nitrous Oxide and/or IV Sedation	50%	0%
Consultations	100% Dental deductible does not apply.	0%
Adjunctive General Services	Not Covered	0%
Medically Necessary Orthodontics, with the Carrier's prior approval and a written plan of care	50% Dental deductible does not apply.	0%

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

   The Covered Person must continue to reside in the geographic area served by the Carrier. Should the Covered Person change residence to a geographic area outside the area served by the Carrier and wish to continue coverage, the Covered Person must transfer coverage to the Blue Cross and Blue Shield plans that serve the area of new residence.

   No benefit will be provided for services, supplies or charges:

   - Which are not Medically Necessary as determined by the Carrier for the diagnosis or treatment of illness or injury;

   - Which are Experimental/Investigative in nature, except, as approved by the Carrier, Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Contract;

   - Which were Incurred prior to the Covered Person's Effective Date of coverage;

   - Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the "Benefits After Termination Of Coverage" subsection of this Contract;

   - For any loss sustained or expenses Incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared;

   - While a Covered Person is incarcerated in any adult or juvenile penal or correctional facility or institution;

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

   - For which a Covered Person would have no legal obligation to pay;

   - For Claims paid or payable by Medicare when Medicare is primary. For purposes of this Contract exclusion, coverage is not available for a service, supply or charge that is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits. The amount excluded for these claims will be either the amount "payable under Medicare" or the applicable plan fee schedule for the service, at the discretion of the Carrier;

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

   - To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;

   - For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified

self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;

- Which are not billed and performed by a Provider as defined under this Contract as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled:
  (a) "Habilitative Therapy Services";
  (b) "Rehabilitative Therapy Services";
  (c) "Therapy Services" (that identifies covered Therapy Services as provided by licensed therapists); and
  (d) "Ambulance Services/Transport"
  of the ***Description of Benefits*** section of this Contract;

- Rendered by a member of the Covered Person's Immediate Family;

- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;

- For ambulance services/transport except as specifically provided in the Ambulance Services/Transport benefit as specified in the ***Description of Benefits*** section of this Contract;

- For services and supplies provided in conjunction with procedures that are determined to be cosmetic under the Contract. A procedure is "cosmetic" if it is designed to improve the appearance of any portion of the body, but is not expected to produce any significant improvement in physiologic function. This "cosmetic" exclusion does not apply to covered surgical procedures performed for: (a) newborns within the first thirty-one (31) days after birth, and beyond that period if continuously covered under this Contract, for care and treatment of medically diagnosed congenital defects or birth abnormalities; (b) reconstructive surgery after mastectomy as required by law; (c) reconstructive surgery performed for the purpose of approximating or restoring original physical appearance from: (1) anomalies caused by an accidental injury; or (2) anomalies caused by previous surgery or other medical intervention to treat illness or disease; or (d) cosmetic procedures necessitated by a covered illness or injury.

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

- For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, naturopathy, hypnotherapy, bioenergetic therapy, Qi Gong, Ayurvedic therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;

- For marriage counseling;

- For Custodial Care, domiciliary care or rest cures;

- For equipment costs related to services performed on high cost technological equipment as defined by the Carrier, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Carrier;

- For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentiogenesis 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 Contract. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated. This exclusion does not apply to dental services provided for the initial treatment of an Accidental Injury/trauma;

- For dental implants for any reason;

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

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

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

- For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;

- For routine foot care, as defined in the Carrier'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;

- For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes, except for orthotics or podiatric appliances required for the prevention of complications associated with diabetes;

- For 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;

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

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

- For treatment of obesity, including surgical treatment of obesity and pharmacological drugs for the treatment of obesity management. This exclusion does not apply to nutrition counseling visits/sessions as described in the "Nutrition Counseling" provision under the ***Description of Benefits*** section of this Contract;

- 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;

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

- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated in this Contract;

- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

- For Orthoptic/Pleoptic therapy;

- For preventive services except as specifically provided for in the Primary and Preventive Care subsection in the ***Description of Benefits*** section of this Contract;

- For weight reduction and premarital blood tests;

- For preventive screening examinations, except for mammograms and those screening examinations listed under "Pediatric Preventive Care", "Adult Preventive Care", "Women's Preventive Care", and "Diagnostic Services" in the ***Description of Benefits*** section of this Contract;

- For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;

- For immunizations required for employment purposes or travel;

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

- For care in a: (a) long term care facility, including a: (1) nursing home; (2) assisted living facility; and (3) board and care home; (b) continuing care retirement facility; (c) convalescent home; (d) school, with the exception of behavioral health services specified in the Carrier’s Medical Policies; (e) camp, with the exception of behavioral health services specified in the Carrier’s Medical Policies; or (f) institution for intellectually disabled children;

- For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided or allowed in the "Treatment for Alcohol or Drug Abuse and Dependency" or "Transplant Services" sections of the ***Description of Benefits***;

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

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

- For medication other than Prescription Drugs unless such medication is administered on an Inpatient basis;

- For Prescription Drugs used for Experimental/Investigative purposes, or Prescription Drugs prescribed or used for cosmetic purposes (such as hair growth or wrinkle removal, etc.);

- 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, and 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 benefit in the ***Description of Benefits*** section of this Contract;

- 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);

- For Inpatient and Outpatient Private Duty Nursing services;

- For charges Incurred for expenses in excess of Benefit Maximums as specified in the ***Schedule of Benefits*** of this Contract;

- For research studies;

- 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 injury caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy);

- For Self-Administered Prescription Drugs, 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:
  (a) Covered under the "Prescription Drugs/Medicines" subsection of the ***Description of Benefits*** section of this Contract;
  (b) Mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes; or
  (c) Required for treatment of an emergency condition that requires a Self-Administered Drug;

- For Convenience Pack drugs which combine two or more individual drug products into a single package with a unique national drug code;

- For Liposuction (Suction-Assisted Lipectomy) for the treatment of lipedema. This exclusion does not apply to: (a) Liposuction (Suction-Assisted Lipectomy) for the treatment of lipedema when the Carrier: (1) Determines the Liposuction (Suction-

Assisted Lipectomy) is Medically Necessary; and (2) 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);

- 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 eighteen (18) months after the accelerated approval.**

  Monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease (e.g., aducsnumab-avwa)

  Delandistrogene moxeparvovec

  Tofersen

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

  Lecanemab-irmb (Leqembi)

- 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.

- For any other service or treatment except as provided in this Contract.

5. GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE ON A CLASS BASIS:

The Contract can be renewed on an annual basis on the anniversary date which is January 1 except for:

a. nonpayment of the requested premium; or

b. fraud or intentional misrepresentation of a material fact; or

c. the carrier non-renews the Contract form for all enrolled persons. In such case, the Carrier will provide notice to each Covered Person at least ninety (90) days prior to the date of discontinuance of such coverage. Such notice will provide enrolled persons with the option to purchase any other individual health insurance coverage currently offered by the Carrier. (The person may apply for a new direct pay coverage, without proof of insurability, by applying within sixty (60) days of such termination. The direct pay coverage will be the same coverage, or one that nearly approximates the coverage of the Contract, if the original Contract form is no longer offered by the Carrier, and will be effective on the date that coverage terminated under the prior coverage at the rate then in effect); or

d. the Carrier non-renews the Contract because it elects to discontinue offering all health insurance coverage in the individual market in Pennsylvania. In such case, the Carrier will provide notice to all enrolled persons and the Pennsylvania Insurance Department of such discontinuance at least 180 days prior to the date of the expiration of the coverage; or

e. the Carrier non-renews the Contract because the Covered Person no longer resides in the geographic area served by the Carrier. Should the Covered Person change residence to a geographic area outside the area served by the Carrier and wishes to continue coverage, the Covered Person must transfer coverage to the Blue Cross and Blue Shield plan that serves the area of new residence.

f. In the case of a Dependent who is no longer eligible for coverage under the Contract, the Dependent may apply for a new direct pay coverage, without proof of insurability, by applying within sixty (60) days of such termination. The direct pay coverage will be the same coverage, or one that nearly approximates the coverage of the Contract, if the original Contract form is no longer offered by the Carrier, and will be effective on the date that coverage terminated under the prior coverage at the rate then in effect.

Non-renewal shall not be based on any health status related to a Covered Person.

The Applicant must make timely payment of all premium due.

a. The premium rates for this Contract 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 Contract 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.

b. The Carrier reserves the right to change the premium for the Contract on a class basis.

c. Any change in the premium rates shall become effective upon the expiration of the period covered by the Applicant's current premium as applied by the Carrier. The Applicant shall be given notice of such change, and payment of the new premium rate shall be considered receipt of notice and acceptance of the change in the premium rate. In the event the Applicant fails to make payment of the new premium within thirty (30) days after the new premium rate became due and payable (see the "Grace Period" subsection of the ***General Provisions*** of the Contract), the Contract shall terminate automatically on the last day of the grace period.

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 Contract will be a Calendar Year.

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL PREFERRED PROVIDER POLICY (PERSONAL CHOICE®)

is issued by

QCC INSURANCE COMPANY
(Called the Carrier)

A Pennsylvania corporation
Located at:
1901 Market Street
Philadelphia, PA 19103

This Contract is a health policy that provides, to Covered Persons, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to the Deductibles and Coinsurance provisions. This Comprehensive Major Medical Contract is marketed by the Carrier as a Preferred Provider Organization benefit program that utilizes a Preferred Provider Network to maximize benefits while offering Covered Persons the choice of selecting Non-Preferred Providers, except where specifically prohibited by the Contract, subject to a reduction of benefits. This Contract utilizes extensive Precertification and utilization management procedures which must be followed to maximize benefits and avoid penalties. Failure to obtain Precertification for services provided by a BlueCard Provider or an out-of-network (Non-Preferred) Provider will result in a 50% reduction in benefits. This coverage does not supplement any basic hospital or basic medical insurance coverage.

NOTICE OF COVERED PERSON'S RIGHT TO EXAMINE CONTRACT: The Applicant has a right to return this Contract within ten (10) days of delivery for refund of the full premium paid if, after examination of this Contract, the Applicant is not satisfied for any reason. This Contract may be returned to: QCC Insurance Company, 1901 Market Street, Philadelphia, PA 19103. If the Contract is returned, it will be null and void from the beginning and no benefits will be payable under its terms.

NOTE: READ THIS PROVISION CAREFULLY

GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE ON A CLASS BASIS: This Contract can be renewed on an annual basis on the anniversary date which is January 1 except for:

a. nonpayment of the required premium; or
b. fraud or intentional misrepresentation of a material fact; or
c. the Carrier non-renews this Contract form for all enrolled persons. In such case, the Carrier will provide notice to each Covered Person at least ninety (90) days prior to the date of discontinuation of such coverage. Such notice will provide enrolled persons with the option to purchase, without proof of insurability any other individual health insurance coverage currently offered by the Carrier; or

Guaranteed renewable provisions continue on page (2) of this Contract form.

THIS IS A NON-PARTICIPATING CONTRACT

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross - independent licensees of the Blue Cross and Blue Shield Association.

d. the Carrier non-renews this Contract because it elects to discontinue offering all health insurance coverage in the individual market in Pennsylvania. In such case**,** the Carrier will provide notice to all enrolled persons and the Pennsylvania Insurance Department of such discontinuation at least one hundred and eighty (180) days prior to the date of the expiration of the coverage; or
e. the Carrier non-renews this Contract because the Covered Person no longer resides in the geographic area served by the Carrier. Should the Covered Person change residence to a geographic area outside the area served by the Carrier and wishes to continue coverage, the Covered Person must transfer coverage to the Blue Cross and Blue Shield plan that serves the area of new residence.

Nonrenewal shall not be based on any health status-related factors of a Covered Person.

The Applicant must make timely payment of all premium due.

a. The premium rates, at any given time, are those listed in the Schedule of Rates on file with the Pennsylvania Insurance Department.

b. The Carrier reserves the right to change the premium rate for the Contract on a class basis.

c. Any change in the premium rates shall become effective upon the expiration of the period covered by the Applicant's current premium payment as applied by the Carrier. The Applicant shall be given notice of such change, and payment of the new premium rate shall be considered receipt of notice and acceptance of the change in premium rate. In the event the Applicant fails to make payment of the new premium rate within thirty (30) days after the new premium rate became due and payable (see the "Grace Period" subsection of the ***General Provisions*** of this Contract), this Contract shall terminate automatically on the last day of the grace period.

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 Contract will be a Calendar Year.

QCC INSURANCE COMPANY

INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL PREFERRED PROVIDER POLICY (PERSONAL CHOICE®)

In Consideration of the Applicant's Application and payment of the appropriate premium, the Covered Persons defined herein are entitled to the Comprehensive Major Medical benefits set forth in accordance with the terms and condition specified.

QCC INSURANCE COMPANY



Koleen Cavanaugh
SVP and Chief Marketing Officer

Attest:



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 1-800-275-2583 (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 àtìlẹhin èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtìlẹhìn 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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IMPORTANT NOTICES:

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY:
The Carrier only covers treatment which it determines Medically Necessary. A Preferred Provider accepts the Carrier's decision and contractually is not permitted to bill the Covered Person for treatment which the Carrier determines is not Medically Necessary unless the Preferred Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Carrier, and that the Covered Person will be financially responsible for such services. A Non-Preferred Provider, however, is not obligated to accept the Carrier's determination and the Covered Person may not be reimbursed for treatment which the Carrier determines is not Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred Provider. The Covered Person can avoid these charges simply by choosing a Preferred Provider for care. The term "Medically Necessary" is defined in the ***Definitions*** section of this Contract.

REGARDING "EXPERIMENTAL/INVESTIGATIVE" TREATMENTS:
The Carrier does not cover treatment which it determines to be Experimental/Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or other governmental agencies. However, the Carrier acknowledges that situations exist when a Covered Person and the Covered Person's Professional Provider agree to utilize an Experimental/Investigative treatment. If a Covered Person receives Experimental/Investigative treatment, the Covered Person is responsible for the cost of the treatment. The Covered Person or the Covered Person's Professional Provider may contact the Carrier to determine whether a treatment is considered Experimental/Investigative.

The terms Experimental/Investigative and Professional Provider are defined in the ***Definitions*** section of this Contract.

REGARDING TREATMENT FOR COSMETIC PURPOSES:
The Carrier does not cover treatment which it determines is for cosmetic purposes unless it is necessitated as part of the Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Carrier acknowledges that situations exist when a Covered Person and the Covered Person's Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Covered Person is responsible for the cost of the treatment. A Covered Person or the Covered Person's Physician may contact the Carrier to determine whether treatment is for cosmetic purposes.

The exclusion for services and operations for cosmetic purposes is detailed in the ***Exclusions*** section of this Contract.

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

Covered Person or their Provider should contact the Carrier 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 Carrier maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

REGARDING USE OF NON-PREFERRED PROVIDERS:
While Personal Choice has an extensive network, it may not contain every provider that you elect to see. To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the Personal Choice Network or is a BlueCard Provider.

In addition, your Personal Choice program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles and Coinsurance. In certain instances, the Non-Preferred Provider also may charge you for the balance of the Provider's bill. This is true regardless of the reason the Member uses an Out-of-Network Provider including, but not limited to, by choice, for level of expertise, for convenience, for location, because of the nature of the services, based on the recommendation of a provider or network sufficiency. However, if Emergency Care is provided by certain Non-Preferred Providers (For example, ambulance services), in accordance with applicable law, the Carrier will reimburse the Non-Preferred Provider at a Preferred rate directly. In this instance the specified Non-Preferred Provider will not bill the Covered Person for amounts in excess of the Carrier's payment for Emergency Care. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of "Covered Expense."

For Covered Services received from a Non-Preferred Provider, payment will be made directly to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Provider. However, the Carrier reserves the right, in its sole discretion, to make payments directly to the Non-Preferred Provider.

The Carrier may approve Covered Services provided by a Non-Preferred Provider subject to Preferred "In-Network" cost-sharing (Coinsurance and Deductibles), if such cost-sharing is applicable to your program, if you have: (a) sought care from a Preferred Provider in the same specialty as the Non-Preferred Provider; (b) been advised by the Preferred Provider that there are no Preferred Providers that can provide the requested Covered Services; and (c) obtained authorization from the Carrier prior to receiving care. The Carrier reserves the right to make the final determination whether there is a Preferred Provider that can provide the Covered Services. If the Carrier approves the use of a Non-Preferred Provider, you will not be responsible for the difference between the provider's billed charges and the Carrier's payment to the Provider. Applicable program terms including Medical Necessity and precertification will apply.

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

REGARDING NON-DISCRIMINATION RIGHTS:
The Covered Person has the right to receive health care services without discrimination:

A. Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity, pre-existing conditions, health status, and marital status;
B. 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;
C. 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;

D. Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

COMPREHENSIVE MAJOR MEDICAL PREFERRED PROVIDER POLICY
(PERSONAL CHOICE®)

TABLE OF CONTENTS

SECTION DE - DEFINITIONS 61
SCHEDULE OF BENEFITS 84
SECTION DB – DESCRIPTION OF BENEFITS 109
- **Primary and Preventive Care 110**
- **Inpatient Benefits 112**
- **Inpatient/Outpatient Benefits 114**
- **Outpatient Benefits 120**

SECTION EX - EXCLUSIONS 140
SECTION GP – GENERAL PROVISIONS 146
- **Entire Contract; Changes 146**
- **Time Limit on Certain Defenses 146**
- **Grace Period 146**
- **Reinstatement 146**
- **Legal Actions 146**
- **Effective Date and Term 146**
- **Benefits to Which Covered Persons are Entitled 147**
- **Termination of the Contract 147**
- **Change in Status and Charges 147**
- **Benefits After Termination of Coverage 149**
- **Release of Information 150**
- **Covered Person/Provider Relationship 150**
- **Identification Cards 150**
- **Applicable Law 150**
- **Notice 150**
- **Coordination of Benefits 150**
- **Subrogation and Reimbursement Rights 152**
- **Payment of Providers 153**
- **BlueCard® Program 160**
- **Limitations of Carrier Liability 162**
- **Right to Enforce Contract Provisions 162**
- **Special Circumstances 163**
- **Premium Rates 163**
- **Disclosure 163**
- **Discounts and Wellness/Reward Incentives Programs 163**
- **Identity Protection Services 164**

SECTION CL - CLAIMS 165
- **Notice of Claim 165**
- **Furnishing Claim Forms 165**
- **Proofs of Loss 165**
- **Time of Payment of Claims 165**
- **Physical Examination and Autopsy 165**
- **Payment of Claims 165**
- **Right to Recover Payments in Error 165**

SECTION MC – MANAGED CARE 166
- **Utilization Review Process 166**
- **Clinical Criteria, Guidelines and Resources 167**
- **Delegation of Utilization Review Activities and Criteria 167**
- **Disease Management and Decision Support Programs 168**
- **Precertification Review 168**
- **Other Precertification Requirements 171**

Out-of-Area Care for Dependent Students 172
SECTION MR – YOUR MEMBERSHIP RIGHTS AND RESPONSIBILITIES 173
SECTION RS – RESOLVING PROBLEMS 174
Complaint Process 174
Appeal Process 174

SECTION DE – DEFINITIONS

For the purposes of this Contract, 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 in the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the U.S. 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 Carrier 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 Carrier'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 Carrier of a Covered Person's eligibility for coverage under a health insurance policy or noncompliance with an administrative policy.
C. A rescission of coverage determination by the Carrier.

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

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE - Complementary and alternative medicine, 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, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the Carrier and which:

A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
C. does not provide Inpatient accommodations; and
D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

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

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 Covered Person from a Non-Preferred Provider.
C. Rescission of coverage (except for failure to pay premiums or coverage contributions) that has not been resolved by the Carrier 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 Carrier 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 Contract and with whom the Carrier has contracted to provide this coverage.

APPLICATION - the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Carrier.

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

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 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.

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 the ***Schedule of Benefits*** of this Contract during which charges for Covered Services must be Incurred in order to be eligible for payment by the Carrier. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

BIRTH CENTER - A Facility Provider approved by the Carrier which:
A. Is licensed as required in the state where it is situated;
B. Is primarily organized and staffed to provide maternity care; and
C. Is under the supervision of a Physician or a licensed certified midwife.

BLUECARD PROGRAM - A program that allows a Covered Person travelling or living outside of their plan's area to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard Program.

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

BRAND NAME OR 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 law and regulations. For purposes of this coverage, 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.

CARE COORDINATOR FEE - A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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

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

COGNITIVE REHABILITATIVE THERAPY - Medically prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system injury (e.g. trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or re-establish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities which mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a physician, neuropsychologist, psychologist, as well as a physical, occupational or speech therapist using a team approach.

COINSURANCE - a type of cost-sharing in which the Covered Person assumes a percentage of the Covered Expenses for Covered Services (such as 20%).

COMPENDIA - one of several tools the Carrier will use to determine what services and supplies will be covered by the Carrier. 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 Carrier will access up-to-date compendia to make coverage decisions.

The Carrier 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.

CONTRACT - this Contract, including the application, and any riders and/or endorsements, is the Contract between the Carrier and the Applicant.

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.

CONVENIENCE PACK - 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).

COPAYMENT - a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as a $15 Copayment per office visit).

COVERED DRUG - Prescription Drugs, including Self-Administered Prescription Drugs, which are:

A. Appearing on the Drug Formulary, or where an exception has been granted pursuant to the Formulary Exception Policy;
B. Prescribed for a Covered Person by a Health Care Practitioner who is appropriately licensed to prescribe Drugs;
C. Prescribed for a use that has been approved by the Federal Food and Drug Administration; and
D. Medically Necessary, as determined by the Carrier.

Insulin shall be considered a Covered Drug where Medically Necessary.

COVERED EXPENSE - refers to the basis on which a Covered Person's Deductibles, Coinsurance, and benefits are calculated.

A. For Covered Services provided by a Facility Provider, the term "Covered Expense" means the following:
    1. For Covered Services provided by a Preferred Facility Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier.
    2. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Facility Provider's charges for Covered Services.
    3. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by the applicable Carrier's proprietary fee schedule for the closest analogous Covered Service.
B. For Covered Services provided by a Professional Provider, Covered Expense means the following:
    1. For Covered Services by a Preferred Professional Provider or BlueCard Provider, "Covered Expense" means the rate of reimbursement for Covered Services the Professional Provider has agreed to accept as set forth by contract with the Carrier, or the BlueCard Provider.
    2. For Covered Services by a Non-Preferred Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Professional Provider's charges for Covered Services.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:
    1. For Covered Services provided by a Preferred Ancillary Provider or BlueCard Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Carrier or BlueCard Provider.
    2. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Carrier's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Carrier's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the Non-Preferred Ancillary Provider's charges for Covered Services.
D. For Prescription Drugs provided by Pharmacies, Covered Expense means the following:
    1. For Prescription Drugs provided by a Preferred Pharmacy, Covered Expense means the amount that the Carrier has negotiated with the Carrier's Pharmacy Benefits Manager as total reimbursement for the covered Prescription Drugs.
    2. For Prescription Drugs provided by a Non-Preferred Pharmacy, Covered Expense means the Pharmacy's charges for the covered Prescription Drugs.
E. For Pediatric Dental Covered Services provided by a Participating Dentist, Covered Expense 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.
F. Nothing in this section shall be construed to mean that the Carrier would provide coverage for services other than Covered Services.

COVERED PERSON - an enrolled Applicant or the Applicant's eligible Dependents who are enrolled under this Contract and for whom the required premium is being paid.

COVERED SERVICE - a service or supply specified in this Contract for which benefits will be provided.

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

DAY REHABILITATION PROGRAM - 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 Contract and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Covered Person returns home each evening and for the entire weekend.

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

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

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 Carrier. When there is a conflict of opinion between the Dentist and the Carrier on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Carrier 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 practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

DEPENDENT -

A. an Applicant's spouse under a legally valid existing marriage;
B. an Applicant's child under the age of twenty-six (26), including any stepchild or legally adopted child, a child placed for adoption or any child whose coverage is the responsibility of the Applicant under the terms of a qualified release or court order;
C. an Applicant's child beyond that age who, as determined by the Carrier, is incapable of self-support due to physical or mental incapacitation, where such incapacitation occurred prior to age twenty-six (26), while covered on the parent contract; and
D. an individual of a Domestic Partnership and the child or children of a Domestic Partner shall be considered for eligibility under the Contract as if they were the Covered Person's own child or children.

If the Covered Person enrolls their Domestic Partner, the Covered Person has an affirmative obligation to notify the Carrier immediately if the Domestic Partnership terminates.

Dependent does not include a person who is: (a) an eligible Applicant; or (b) a member of the armed forces.

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

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

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

- 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;
- Is not related to the other partner by adoption or blood;
- Is the sole Domestic Partner of the other partner, with whom the person has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and
- Demonstrates financial interdependence by submission of proof of three or more of the following documents:
  - A Domestic Partnership agreement;
  - A joint mortgage or lease;
  - A designation of one of the partners as beneficiary in the other partner's will;
  - A durable property and health care powers of attorney;
  - A joint title to an automobile, or joint bank account or credit account; or
  - Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

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

DRUG FORMULARY - a list of Covered Drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable physicians, dentists, and, as appropriate, other practitioners to prescribe all Medically Necessary treatment of a Covered Person's condition.

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

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

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

EFFECTIVE DATE - the date on which coverage for a Covered Person begins under this Contract. The Effective Date is shown on the application for coverage and on the Schedule of Rates.

EMERGENCY - the sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

EMERGENCY CARE - Covered Services and supplies provided by a Hospital or Facility Provider and/or Professional Provider to a Covered Person in or for an Emergency on an Outpatient basis in a Hospital Emergency Room or Outpatient Emergency Facility.

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.

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 ten (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 Covered Person's particular condition;
D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or
E. Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

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

A. 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).
B. 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.
C. Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure or diagnostic test leads to measurable improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
D. 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.
E. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph D, is possible in standard conditions of medical practice, outside clinical investigatory settings.

F. 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 (e.g., An Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of 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 Carrier'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. Free Standing Ambulatory Care Facility;
D. Free Standing Dialysis 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 Care Facility.

FREE STANDING AMBULATORY CARE FACILITY - a Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a Physician. This Facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREE STANDING DIALYSIS FACILITY - a Facility Provider, that has verified to the Carrier that it is: (a) licensed or approved by the appropriate governmental agency; (b) approved by the Carrier; and (c) 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.

HABILITATION THERAPY - Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include Physical and Occupational Therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

HABILITATIVE 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 Covered Person:

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

B. **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.

C. **SPEECH THERAPY**
   Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental 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, that result in communication disabilities and/or swallowing disorders.

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, and (e) implantable (can be partial or complete).

A Hearing Aid is not a cochlear implant.

HOME HEALTH CARE AGENCY - a Facility Provider, approved by the Carrier, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the Covered Person's home in accordance with an approved home health care Plan of Treatment.

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

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

A. is a duly licensed institution;

B. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
C. has organized departments of medicine;
D. provides twenty-four (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 Substance Abuse;
   - Place for provision of rehabilitation care;
   - Place for treatment of pulmonary tuberculosis; or
   - Place for provision of Hospice care.

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

IDENTIFICATION CARD - the currently effective card issued to each Covered Person by the Carrier.

IMMEDIATE FAMILY - the Covered Person's spouse, parent, child, stepchild, brother, sister, or persons who ordinarily reside in the household of the Covered Person.

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

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

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 Covered Person's request for Covered Services. The Carrier arranges for the availability of IROs and assigns them to external Medical Necessity Appeals. IROs are not corporate affiliates of the Carrier.

INPATIENT ADMISSION (or INPATIENT) - the actual entry into a Hospital, Skilled Nursing Care Facility or Facility Provider of a Covered Person 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 Covered Person is actually discharged from the facility.

INPATIENT CARE FOR ALCOHOL OR DRUG ABUSE AND DEPENDENCY - the provision of medical, nursing, counseling or therapeutic services, for Covered Persons suffering from

Alcohol or Drug Abuse or dependency, twenty-four (24) hours a day in a Hospital or Non-Hospital Facility, according to individualized treatment plans.

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

LICENSED CLINICAL SOCIAL WORKER - A social worker who has graduated from a school accredited by the Council on Social Work Education with a Doctoral or Master's Degree and is licensed by the appropriate state authority.

LICENSED PRACTICAL NURSE (LPN) - a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

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.

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

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

MAXIMUM - a limit on the amount of Covered Services that a Covered Person may receive. The Maximum may apply to all Covered Services or selected types. A Maximum may be expressed in number of days or number of services for a specified period of time.

A. **BENEFIT MAXIMUM** - the greatest amount of a specific Covered Service that a Covered Person may receive.
B. **LIFETIME MAXIMUM** - the greatest amount of Covered Services that a Covered Person may receive in the Covered Person's lifetime.

Benefit Maximum and Lifetime Maximum Limits are expressed in day or visit limits, not dollar limits.

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

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

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

MEDICALLY NECESSARY (or MEDICAL NECESSITY) - health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing,

evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; (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 Covered Person's medical needs and condition, based on the Covered Person'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 Carrier'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.

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 Carrier'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 Carrier and did not result in the filing of a Medical Necessity Appeal (written or oral).

MEDICAL POLICY - Medical Policy is used to determine whether Covered Services are Medically Necessary. Medical Policy is developed based on various sources including, but not limited to, peer-reviewed scientific literature published in journals and textbooks, guidelines promulgated by governmental agencies and respected professional organizations and recommendations of experts in the relevant medical specialty.

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

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES - the payment amount, as determined by the Medicare program, for the Covered Services for a Facility Provider.

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

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

MENTAL ILLNESS - any of various conditions categorized as mental disorders by the most current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).

For purposes of this Contract, 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.

METHADONE TREATMENT - Provision and supervision of methadone hydrochloride in prescribed doses for the treatment of opioid dependency.

NEGOTIATED ARRANGEMENT a.k.a., NEGOTIATED NATIONAL ACCOUNT ARRANGEMENT - An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

NON-HOSPITAL FACILITY - a Facility Provider, licensed by the Department of Health for the care or treatment of persons suffering from Alcohol or Drug Abuse or dependency, except for transitional living facilities. Non-Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities and Free Standing Ambulatory Care Facilities for Partial Hospitalization Programs.

NON-HOSPITAL RESIDENTIAL TREATMENT - the provision of medical, nursing, counseling, or therapeutic services to Covered Persons suffering from Alcohol or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

NON-PARTICIPATING DENTIST - A Dentist who has not contracted to limit their charges to Covered Persons.

NON-PREFERRED ANCILLARY PROVIDER - an Ancillary Provider that is not a member of the Personal Choice Network or is not a BlueCard Provider.

NON-PREFERRED DRUG - 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.

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

NON-PREFERRED MAIL ORDER PHARMACY - a Mail Order Pharmacy that is not a member of the Carrier's Pharmacy Benefits Manager's network.

NON-PREFERRED PHARMACY - a Pharmacy that is not a member of the Carrier's Pharmacy Benefits Manager's network.

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

NON-PREFERRED PROVIDER - a Facility Provider, Professional Provider, Ancillary Provider or Pharmacy that is not a member of the Personal Choice Network or is not a BlueCard Provider.

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

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-POCKET LIMIT - a specified dollar amount of Coinsurance, Deductible and Copayment expense Incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include charges which are in excess of the Carrier's total payment for Covered Services whether those services are performed by a Preferred or Non-Preferred Provider or charges for Covered Services that are not Essential Health Benefits. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the ***Schedule of Benefits*** of this Contract.

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

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

PARTIAL HOSPITALIZATION PROGRAM - medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment (Intensive Outpatient 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 Covered Persons.

PEDIATRIC DENTAL COVERED SERVICE(S) - Dental Services shown on the ***Schedule of Benefits*** for which benefits will be covered subject to this Contract when rendered by a Participating Dentist.

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

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

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

PHARMACIST - an individual who is legally licensed to practice the profession of Pharmacology and who regularly practices such profession in a Pharmacy.

PHARMACY - any establishment which is registered and licensed as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

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

PLAN OF TREATMENT - a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should include goals and duration of treatment, and be limited in scope and extent to that care which is Medically Necessary for the Covered Person's diagnosis and condition.

PRECERTIFICATION (or PRECERTIFY) - prior assessment by the Carrier or designated agent that proposed services, such as hospitalization, are Medically Necessary for a particular patient, and are covered by the patient's Personal Choice coverage. Payment for services depends on whether the patient and the category of service are covered under this Contract.

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

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

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

PREFERRED MAIL ORDER PHARMACY - a Pharmacy that is a member of the Carrier's Pharmacy Benefit Manager's network and has agreed to a rate of reimbursement determined by contract to provide Covered Persons with mail order prescription drug services.

PREFERRED PHARMACY - a Pharmacy that is a member of the Carrier's Pharmacy Benefit Manager's network and has agreed to a rate of reimbursement determined by contract to provide to the Carrier's PPO members Prescription Drugs at an "in-network" level of benefits.

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

PREFERRED PROVIDER - a Facility Provider, Professional Provider, or Ancillary Provider that is a member of the Personal Choice Network or is a BlueCard Provider, or with respect to Pharmacy, a member of the Carrier's Pharmacy Benefits Manager's network, authorized to perform specific Covered Services at the Preferred level of benefits.

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

PRESCRIPTION DRUG - means: (a) any medication approved by the Carrier and which by Federal and or state laws may be dispensed with a Prescription Order, and (b) insulin. The list of covered Prescription Drugs is subject to change from time to time at the sole discretion of the Carrier. For purposes of this coverage, "Prescription Drug" shall also mean devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

PRESCRIPTION ORDER - the request in accordance with applicable laws and regulations for medication issued by a Professional Provider.

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

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

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

PROFESSIONAL PROVIDER - A person or practitioner with an unrestricted, unsanctioned license, who is licensed where required and performing services within the scope of such licensure. Professional Provider includes, but are not limited to:

A. Audiologist;
B. Autism Service Provider;
C. Certified Midwife;
D. Certified Registered Nurse;
E. Chiropractor;
F. Dentist;
G. Independent Clinical Laboratory;
H. Licensed Clinical Social Worker;
I. Master's Prepared Therapist;
J. Optometrist;
K. Physical Therapist;
L. Physician;
M. Physician Assistant;
N. Podiatrist;
O. Psychologist;
P. Speech-Language Pathologist;
Q. Teacher of the Hearing Impaired.

PROSTHETIC DEVICES (or PROSTHETICS) - devices (except dental Prosthetics), which replace all or part of: an absent body organ including contiguous tissue; or the function of a permanently inoperative or malfunctioning body organ.

PROVIDER - a Facility Provider, Professional Provider, Ancillary Provider or Pharmacy, licensed where required.

PROVIDER INCENTIVE - An additional amount of compensation paid to a healthcare provider by a payer/Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group/population of Covered Persons.

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

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

QUALIFIED INDIVIDUAL (for Clinical Trials) - a Covered Person who meets the following conditions:

A. The Covered Person 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 Covered Person's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or
   2. The Covered Person provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Covered Person 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 of 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 Carrier as a Qualifying Clinical Trial.

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, that has verified to the Carrier that it is: (a) licensed or approved by the Carrier, which is appropriate governmental agency and (b) 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 - Includes treatments designed to improve, maintain, and prevent the deterioration of skills and functioning for daily living that have been lost or impaired.

REHABILITATIVE 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 Covered Person:

A. **OCCUPATIONAL THERAPY**
   Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by

illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

B. **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.

C. **SPEECH THERAPY**
Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental 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, that result in communication disabilities and/or swallowing disorders.

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 Carrier, which provides treatment for Mental Illness and Serious Mental Illness or for Alcohol and Drug Abuse and Dependency to partial, outpatient or live-in patients who do not require acute Medical Care.

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.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS - Routine patient costs include all items and services consistent with the coverage provided under this Contract 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 Covered Person or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self-Administered Prescription Drugs include, but are not limited to:

- Oral drugs;
- Self-Injectable Drugs;

- Inhaled drugs; and
- Topical drugs.

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

A. Is introduced into a muscle or under the skin with a syringe and needle; and
B. Can be administered safely and effectively by either the Covered Person 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.

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

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

SKILLED NURSING CARE FACILITY - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or alcohol or drug abuse, which:

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

SLEEP STUDIES - the continuous and simultaneous monitoring and recording of various physiological 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:

A. Stable;
B. Functional;
C. Free from decay and advanced periodontal disease;
D. In good repair at the time of the Accidental Injury/trauma; and
E. Are not man-made.

SPECIALIST SERVICES - All services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

SPECIALTY DRUG - either of the following:

A. A Prescription Drug prescribed to a Covered Person 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 dose 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 Covered Person.
3. The drug is prescribed for a Covered Person 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 Covered Person 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 Carrier 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 Professional Provider.

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

THERAPY 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 Covered Person:

A. **CARDIAC REHABILITATION THERAPY**
Medically supervised rehabilitation program designed to improve a Covered Person's tolerance for physical activity or exercise.

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

C. **DIALYSIS** - the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. **INFUSION THERAPY** - The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a healthcare Provider. Infusion may be provided in a variety of settings (e.g., home, office, outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Covered Person. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Carrier.

E. **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, radioactive isotopes, or other radioactive substance regardless of the method of delivery.

G. **RESPIRATORY THERAPY**
Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

URGENT CARE - Urgent care needs are for sudden illness or Accidental injury that require prompt medical attention but are not life-threatening and are not emergency medical conditions when your Professional Provider is unavailable. Examples of urgent care needs include stitches, fractures, sprains, ear infections, sore throats, rashes, X-rays that are not Preventive Care.

URGENT CARE CENTERS - a Facility Provider designed to offer immediate evaluation and treatment for acute health conditions that require medical attention in a non-emergency situation when your Professional Provider's office is unavailable. Urgent Care is not the same as emergency care (see definition of ***Urgent Care*** above).

VALUE-BASED PROGRAM (VBP) - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

SCHEDULE OF BENEFITS

Subject to the ***Exclusions***, conditions and limitations of this Contract, a Covered Person is entitled to benefits for Covered Services and Covered Expenses described in this section during a Benefit Period, subject to the Deductible, Coinsurance, Copayment and Benefit Maximum amounts as specified below. With the exception of Emergency Care Services, which are paid at the Preferred (In-Network) level of benefits, regardless of whether the Provider was a Preferred or Non-Preferred (Out-of-Network) Provider, benefits payable for Covered Services which are not provided by a Preferred (In-Network) Provider, are subject to the application of a higher Coinsurance level and Deductible amount as described below:

The percentages for your Coinsurance and Covered Services shown below are not always calculated on actual charges. For an explanation on how coinsurance is calculated, see the "Covered Expense" definition in the ***Definitions*** section of this Contract.

BENEFIT PERIOD	Calendar Year (1/1 - 12/31)
PROGRAM DEDUCTIBLE ***(Covered Person's Responsibility)***	
Covered Person's Deductible ***(Single Coverage)***	
Preferred Care	None.
Non-Preferred Care	$6,000 per Covered Person per Benefit Period for Non-Preferred Covered Services. This Deductible applies to all Non-Preferred Covered Services except as otherwise specified.
Family Deductible ***(Family Coverage)***	
Preferred Care	None.

Family Deductible ***(Family Coverage)*** **(Continued)**	
Non-Preferred Care	The family Deductible amount is equal to two (2) times the individual Deductible in each Benefit Period for Non-Preferred Covered Services, it will be applied for all family members covered under a Family Coverage. A Deductible will not be applied to any covered individual family member once that covered individual has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.
Deductible Carryover	Expenses Incurred for Covered Expenses in the last three (3) months of the initial Benefit Period which were applied to that Benefit Period's Deductible will be applied to the Deductible of the next Benefit Period. This only applies to Covered Persons who enroll in the fourth quarter of the initial Benefit Period.
COINSURANCE ***(Covered Person's Responsibility)***	
Preferred Care	20% for most Preferred Covered Services, except as otherwise specified in the ***Schedule of Benefits***.
Non-Preferred Care	50% for most Non-Preferred Covered Services, except as otherwise specified in the ***Schedule of Benefits***.
OUT-OF-POCKET LIMIT	
INDIVIDUAL OUT-OF-POCKET LIMIT ***(Single Coverage)***	
Preferred Care	When a Covered Person Incurs $8,750 of Copayment and Coinsurance expense for Essential Health Benefits in one Benefit Period for Preferred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of the Benefit Period. The dollar amounts specified shall not include any expense Incurred for a Penalty amount.
Non-Preferred Care	When a Covered Person Incurs $12,000 of Coinsurance and Deductible expense in one Benefit Period for Non-Preferred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. The dollar amounts specified shall not include any expense Incurred for a Penalty amount.

OUT-OF-POCKET LIMIT (Continued)	
FAMILY OUT-OF-POCKET LIMIT *(Family Coverage)*	
Preferred Care	After two (2) times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage for Essential Health Benefits in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount.
Non-Preferred Care	After two (2) times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount.
LIFETIME MAXIMUM	
Preferred Care	Unlimited.
Non-Preferred Care	Unlimited.

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
OFFICE VISITS/RETAIL CLINICS/TELEMEDICINE VISITS*		
Office Visits/Retail Clinics	100%, after a Copayment of $30 per Provider per date of service.	50%
Telemedicine Visits (excluding Retail Clinics)	100%, after a Copayment of $20 per Provider per date of service.	50%
*If a Covered Person receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.		
PEDIATRIC PREVENTIVE CARE Deductible does not apply.	100%	50%
IMMUNIZATIONS Deductible does not apply.	100%	50%
ADULT PREVENTIVE CARE Deductible does not apply.	100%	50%
PREVENTIVE COLONOSCOPY Deductible does not apply.		
Preventive Plus (P+) Facility/Non-Hospital Based Facility*	100%	50%

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Non-Preventive Plus (P+) Facility/Hospital Based Facility * For $0 (100%) Covered Person cost-sharing to apply, all services must be performed by a Preferred gastroenterologist or a colon and rectal surgeon. ** The Copayment will be waived if the Preferred Provider determines that it is Medically Necessary to have the service performed by a Provider that is Hospital based. There is no cost-share applied if the preventive colonoscopy service is performed at a facility that is not Hospital based (i.e., an Ambulatory Surgical Facility); if the 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 (P+) Providers, colonoscopy screenings must meet the United State Preventive Services Task Force's (USPSTF) guidelines for $0 (100%) Covered Person cost-sharing to apply.	100%, after a Copayment of $750 per Provider per date of service**.	50%

PRIMARY AND PREVENTIVE CARE	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
SMOKING CESSATION Deductible does not apply.	100%	50%
WOMEN'S PREVENTIVE CARE Deductible does not apply.	100%	50%
ROUTINE GYNECOLOGICAL EXAMINATION, PAP SMEAR One (1) examination per Benefit Period. Deductible does not apply.	100%	50%
MAMMOGRAMS Deductible does not apply.	100%	50%
NUTRITION COUNSELING Maximum of six (6) Preferred/Non-Preferred visits per Benefit Period. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%	50%

INPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
HOSPITAL SERVICES * In the event of a Non-Preferred Inpatient Emergency admission, all benefits will be provided at the Preferred level of benefits; and the out of pocket expense will be no higher than if services were provided by a Preferred Provider.	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50%* Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
MEDICAL CARE Cost-sharing does not apply to physician/surgeon fees (including Inpatient anesthesia) that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80%	50%
SKILLED NURSING CARE FACILITY Maximum of 120 Preferred/Non-Preferred Inpatient days per Benefit Period. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $375 per day, to a maximum of $1,875, per admission.	50%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
BLOOD Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80%	50%
HOSPICE SERVICES Respite Care: Maximum of seven (7) Preferred/Non-Preferred days every six (6) months. Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%	50%
MATERNITY/OB-GYN/FAMILY SERVICES		
Maternity/Obstetrical Care		
Professional services	100%, after a Single Copayment of $65	50%
Facility services: Inpatient/Birthing Center	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission.	50%
Elective Abortions		
Professional services	100%, after a Copayment of $65 per procedure.	50%
Outpatient Facility services		
Ambulatory Surgical Facility	100%, after a $300 Copayment per procedure.	50%
Hospital based	100%, after a $700 Copayment per procedure.	50%
Newborn Care * There is no cost-share applied for Gonorrhea eye drops for newborns. Cost-sharing does not apply for the first thirty-one (31) days following birth.	100%*	50%
Artificial Insemination	100%, after a Copayment of $65 per procedure.	50%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
SURGICAL SERVICES		
Ambulatory Surgical Facility Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a $300 Copayment per day.	50%
Hospital based Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a $700 Copayment per day.	50%
Outpatient Professional Charge Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80%	50%
Outpatient Anesthesia Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80%	50%
Second Surgical Opinion		
Office Visits	100%, after a Copayment of $65 per service/occurrence.	50%
Telemedicine Visits	100%, after a Copayment of $45 per service/occurrence.	50%
If more than one (1) surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.		

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
MENTAL HEALTH/PSYCHIATRIC CARE		
Inpatient Treatment	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
Outpatient Treatment		
Office Visit	100%, after a Copayment of $65 per Provider per date of service.	50%
All Other	100%, after a Copayment of $65 per Provider per date of service.	50%
Telebehavioral Health	100%	50%
TRANSPLANT SERVICES		
Inpatient Facility Charges	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission.	50%
Outpatient Facility Charges	100%, after a $300 Copayment per procedure.	50%

INPATIENT/OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
TREATMENT OF ALCOHOL OR DRUG ABUSE AND DEPENDENCY		
Inpatient Hospital Detoxification and Rehabilitation	100%, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
Hospital and Non-Hospital Residential Care	100 %, after a Copayment of $750 per day, to a maximum of $3,750, per admission. Benefit Period Maximum: Unlimited Preferred Inpatient days. This maximum is combined for all Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits.	50% Benefit Period Maximum: Seventy (70) Non-Preferred Inpatient days. This maximum is combined for all Non-Preferred Inpatient Hospital Services, Mental Health/Psychiatric Care (including Treatment for Serious Mental Illness) and Treatment for Alcohol or Drug Abuse and Dependency benefits. This maximum is part of, not separate from, Preferred days maximum.
Outpatient Treatment		
Office Visit	100%, after a Copayment of $65 per Provider per date of service.	50%
All Other	100%, after a Copayment of $65 per Provider per date of service.	50%
Telebehavioral Health	100%	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
AMBULANCE SERVICES/TRANSPORT **Emergency** Deductible does not apply. **Non-emergency** * The Covered Person's out of pocket expense for emergency services will be no higher than if services were provided by a Preferred Provider.	100%, after a Copayment of $100. 100%, after a Copayment of $150.	100%, after a Copayment of $100.* 50%
AUTISM SPECTRUM DISORDERS Benefit Period Maximums and visit limits do not apply.	For services that are prescribed for Autism Spectrum Disorders, the cost-sharing will be the lesser of the applicable Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the medical service cost-share.	For services that are prescribed for Autism Spectrum Disorders, the cost-sharing will be the lesser of the applicable Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the medical service cost-share.
DAY REHABILITATION PROGRAM Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions. Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	80% per service/occurrence.	50%
DIABETIC EDUCATION PROGRAM	100%	0% Benefits for Non-Preferred services are not available.
DIABETIC EQUIPMENT AND SUPPLIES	50%	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
DIAGNOSTIC SERVICES		
Routine Diagnostic/Radiology Services (including Allergy Testing)		
Freestanding	100%, after a Copayment of $60 per visit.	50%
Hospital Based	100%, after a Copayment of $90 per visit.	50%
Non-Routine Diagnostic/Radiology Services (including MRI/MRA, CT scans, PET scans and Nuclear Cardiology Imaging.)		
Freestanding	100%, after a Copayment of $120 per visit.	50%
Hospital Based	100%, after a Copayment of $160 per visit.	50%
Sleep Studies		
Home/Freestanding Sleep Center	100%, after a $300 Copayment per visit.	50%
Hospital Based	100%, after a $700 Copayment per visit.	50%
Laboratory and Pathology Tests		
Freestanding Laboratory	100%, after a $10 Copayment per visit.	50%
Hospital based Laboratory	100%, after a $85 Copayment per visit.	50%
DURABLE MEDICAL EQUIPMENT AND CONSUMABLE MEDICAL SUPPLIES, PROSTHETICS, ORTHOTICS	50%	50%
Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
EMERGENCY CARE SERVICES Deductible does not apply. * The Covered Person's out of pocket expense will be no higher than if services were provided by a Preferred Provider.	100%, after a Copayment of $400 per service/occurrence. (waived if admitted)	100%, after a Copayment of $400 per service/occurrence.* (waived if admitted)
HABILITATIVE THERAPY SERVICES		
Physical Therapy/Occupational Therapy		
Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions of Physical Therapy/Occupational Therapy combined. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Physical Therapy/Occupational Therapy cost-share.		
Freestanding	100%, after a Copayment of $65 per Provider per date of service.	50%
Hospital Based	100%, after a Copayment of $95 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Speech Therapy Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Speech Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
HOME HEALTH CARE First maternity home health care visit within forty-eight (48) hours of early discharge is exempt from Coinsurance amounts. Benefit Period Maximum: Sixty (60) Preferred/Non-Preferred sessions. Benefit Period Maximum and cost-sharing do not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	$150 Copayment per visit	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
INJECTABLE MEDICATIONS		
Specialty Drugs Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Home/Office	100%, after a Copayment of $120 per visit.	50%
Outpatient	100%, after a Copayment of $240 per visit.	50%
Standard Injectable Drugs	100%, after a Copayment of $60 per visit.	50%
The cost-sharing amounts for injected or infused drugs set forth above are applicable to those injected or infused drugs administered to a Covered Person who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Covered Person does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Covered Person will not accrue toward the satisfaction of the Covered Person's Program Deductible or Out-of-Pocket Limit. Additionally, the Carrier may elect to implement a program whereby each separate injected or infused drug will be paid by the Carrier 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 Covered Person will not result in a Covered Person paying more cost-sharing out of pocket for an injected or infused drug than they would have paid absent the Carrier's application of the program. Covered Persons 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.		
MEDICAL FOODS AND NUTRITIONAL FORMULAS Deductible does not apply.	80%	50%
METHADONE TREATMENT	100%	50%
NON-SURGICAL DENTAL SERVICES	80%	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
PRESCRIPTION DRUGS Deductibles do not apply.		
Retail Pharmacy *** Low-Cost Generic Drugs will be covered at 100%, after a $3 Copayment**	100%, after a Copayment of $20 for Generic Drugs*, and $100 Copayment for Preferred Brand and 50% for Non-Preferred Drugs, up to a Maximum of a $200 amount per prescription or refill.	30%
Specialty Drug Prescription or refill of 1-30 day supply**	50%, or 100% after Covered Person paying 50% reaches Maximum of $1,000 per prescription or refill.	Not Covered
Mail Order Pharmacy† Prescription or refill of 31-90 day supply *** Low-Cost Generic Drugs will be covered at 100%, after a $7.50 Copayment**	100%, after a Copayment of $50 for Generic Drugs*, and $250 Copayment for Preferred Brand and 50% for Non-Preferred Drugs, up to a Maximum of a $500 amount per prescription or refill.	Not Covered
Contraceptives, mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained from a Preferred Pharmacy or Preferred Mail Order Pharmacy for certain generic products and brand products. All other contraceptive products are covered at standard cost-sharing as reflected in this *Schedule of Benefits*.		

** 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 Covered Person who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Covered Person does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Covered Person will not accrue toward the satisfaction of the Covered Person's Program Deductible or Out-of-Pocket Limit. Additionally, the Carrier may elect to implement a program whereby each separate Prescription Order or refill for the Prescription Drug will be paid by the Carrier subject to the Covered Person's Coinsurance of 30%. This 30% Coinsurance associated with a Specialty Drug prescription or for certain other high-cost Prescription Drugs experienced by a Covered Person will not result in a Covered Person paying more cost-sharing out of pocket for a Prescription Drug or refill than they would have paid absent the Carrier's application of the program. Covered Persons 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 drugs to treat chronic conditions are available at the mail order Pharmacy and a designated retail Pharmacy.

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
REHABILITATIVE THERAPY SERVICES **Physical Therapy/Occupational Therapy** Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions of Physical Therapy/Occupational Therapy combined. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Physical Therapy/Occupational Therapy cost-share.		
Freestanding	100%, after a Copayment of $65 per Provider per date of service.	50%
Hospital Based	100%, after a Copayment of $95 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Speech Therapy Benefit Period Maximum: Thirty (30) Preferred/Non-Preferred sessions. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Speech Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
SPECIALIST OFFICE/TELEMEDICINE VISITS*		
Office Visits	100%, after a Copayment of $65 per Provider per date of service.	50%
Telemedicine Visits	100%, after a Copayment of $45 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
SPINAL MANIPULATIONS Benefit Period Maximum: Twenty (20) Preferred/Non-Preferred sessions. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Spinal Manipulations cost-share.	100%, after a Copayment of $50 per Provider per date of service.	50%
THERAPY SERVICES **Cardiac Rehabilitation Therapy** Benefit Period Maximum: Thirty-six (36) Preferred/Non-Preferred sessions. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Cardiac Rehabilitation Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
Chemotherapy Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $65 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Dialysis Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $65 per Provider per date of service.	50%
Infusion Therapy Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.		
Home/Office	100%, after a Copayment of $65 per Provider per date of service.	50%
Outpatient	100%, after a Copayment of $130 per Provider per date of service.	50%
Pulmonary Rehabilitation Therapy Benefit Period Maximum: Thirty-six (36) Preferred/Non-Preferred sessions. For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Pulmonary Rehabilitation Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%

OUTPATIENT BENEFITS	If the Covered Person uses a Preferred Provider, the Carrier will pay:	If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:
Radiation Therapy Cost-sharing does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency.	100%, after a Copayment of $65 per Provider per date of service.	50%
Respiratory Therapy For services that are prescribed for Mental Health/Psychiatric Care, Treatment for Alcohol Or Drug Abuse And Dependency or Autism Spectrum Disorders, the cost-sharing will be the lesser of the Mental Health/Psychiatric Care Outpatient Treatment Office Visit or the Respiratory Therapy cost-share.	100%, after a Copayment of $65 per Provider per date of service.	50%
URGENT CARE CENTER	100%, after a Copayment of $65 per Provider per date of service.	50%

OUTPATIENT BENEFITS *(Continued)*	If the Covered Person utilizes a contracted vendor, the Carrier will pay:	If the Covered Person does not utilize a contracted vendor, the Carrier will pay:
VIRTUAL CARE SERVICES (Vendor/Virtual Provider)		
Telemedicine Visit	100%	Not Covered
Teledermatology	100%	Not Covered
Telebehavioral Health	100%	Not Covered

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Preferred Provider, the Carrier will pay:**	**If the Covered Person uses a Non-Preferred Provider, the Carrier will pay:**
VISION CARE (PEDIATRIC)		
Routine Eye Exams and Refractions	100%	Benefits for Non-Preferred services are not available.
Eyeglasses, including Spectacle Lenses and Frames	100%	Benefits for Non-Preferred services are not available.
Elective Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses		
Davis Collection	100%	Benefits for Non-Preferred services are not available.
Non-Collection	100%, up to a maximum of $150 towards purchase and a 15% discount off balance over the $150 maximum, not available at all Preferred Providers	Benefits for Non-Preferred services are not available.
Elective Contact Lenses Fitting and Follow-up Care		
Standard Lenses	100%	Benefits for Non-Preferred services are not available.
Disposable/Specialty Lenses	100%, up to a maximum of $60 towards purchase and a 15% discount off balance over the $60 maximum, not available at all Preferred Providers	Benefits for Non-Preferred services are not available.
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including standard, specialty and disposable lenses	100%	Benefits for Non-Preferred services are not available.

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Participating Dentist, the Carrier will pay:**	**If the Covered Person uses a Non-Participating Dentist, the Carrier will pay:**
PEDIATRIC DENTAL SERVICES **Dental Deductible: $50 per eligible Covered Person must be met before applicable coinsurance amounts are applied. The Program Deductible does not apply.**		
Service Categories		
Oral Evaluations (Exams)	100% Dental deductible does not apply.	0%
Radiographs (All X-Rays)	50% Dental deductible does not apply.	0%
Prophylaxis (Cleanings)	100% Dental deductible does not apply.	0%
Fluoride Treatments	100% Dental deductible does not apply.	0%
Palliative Treatment (Emergency)	50% Dental deductible does not apply.	0%
Sealants	100% Dental deductible does not apply.	0%

OUTPATIENT BENEFITS *(Continued)*	**If the Covered Person uses a Participating Dentist, the Carrier will pay:**	**If the Covered Person uses a Non-Participating Dentist, the Carrier will pay:**
PEDIATRIC DENTAL SERVICES		
Service Categories (Continued)		
Teledentistry, synchronous or asynchronous	100% Dental deductible does not apply.	0%
Other Diagnostic & Preventive Services	Not Covered	0%
Space Maintainers	50%	0%
Amalgam Restorations (Metal fillings)	50%	0%
Resin-based Composite Restorations (White fillings)	50%	0%
Crowns, Inlays, Onlays	50%	0%
Crown Repair	50%	0%
Endodontic Therapy (Root canals, etc.)	50%	0%
Other Endodontic Services	50%	0%
Surgical Periodontics	50%	0%
Non-Surgical Periodontics	50%	0%
Periodontal Maintenance	50%	0%
Prosthetics (Complete or Fixed Partial Dentures)	50%	0%
Adjustments and Repairs of Prosthetics	50%	0%
Other Prosthetic Services	50%	0%
Maxillofacial Prosthetics	Not Covered	0%
Implant Services	50%	0%
Simple Extractions	50%	0%
Surgical Extractions	50%	0%
Oral Surgery	50%	0%
General Anesthesia, Nitrous Oxide and/or IV Sedation	50%	0%
Consultations	100% Dental deductible does not apply.	0%
Adjunctive General Services	Not Covered	0%
Medically Necessary Orthodontics, with the Carrier's prior approval and a written plan of care	50% Dental deductible does not apply.	0%

SECTION DB - DESCRIPTION OF BENEFITS

Subject to the Exclusions, conditions and limitations of this Contract, a Covered Person is entitled to benefits for Covered Services when: (a) deemed Medically Necessary; and (b) billed for by a Provider. Payment allowances for Covered Services are described in the ***Schedule of Benefits*** of this Contract. Provisions for reimbursement of services provided by Facility Providers and Professional Providers are included under Section GP of this Contract.

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

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

A. Acknowledge this in writing;
B. Request to have services provided; and
C. State the Covered Person's willingness to assume financial liability.

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

The services described below may be provided by either a Preferred or Non-Preferred Provider. However, the Covered Person will maximize the benefits available when services are provided by a Provider that belongs to the Personal Choice Network (a Preferred Provider) and has a contract with the Carrier to provide services and supplies to the Covered Person. Not all Preferred Providers are authorized by the Carrier to be Preferred Providers for all services. Examples include Outpatient radiology or Outpatient laboratory services. Providers that can perform Outpatient radiology or Outpatient laboratory services are listed in the Personal Choice Directory, which provides for the Covered Person a listing of all Preferred Providers by specialty type. The directory is updated periodically throughout the year, and the Carrier reserves the right to add or delete Physicians, Hospitals and/or other Providers at any given time. It is important to note that continued participation of any one Physician, Hospital, or other Provider cannot be guaranteed.

If a Preferred Provider in the Personal Choice Network performs a service for which he is not authorized by the network to perform, the Covered Person will be held harmless if the Preferred Provider fails to provide written notice to the Covered Person that the Provider is not authorized to perform the service.

Covered Person will be held harmless for out of network differentials if:

a. a Preferred Provider in the Personal Choice Network fails to provide written notice to the Covered Person of the Provider's Non-Preferred status for Outpatient radiology or Outpatient laboratory services, and that Provider performs such services; or
b. a Preferred Provider in the Personal Choice Network provides a written order for Outpatient radiology or Outpatient Laboratory services to be performed by a Preferred Provider that has Non-Preferred status for those services, and that Provider performs such services.

PRIMARY AND PREVENTIVE CARE

A Covered Person is entitled to benefits for Primary Care and "Preventive Care" Covered Services when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and other cost-sharing requirements are specified in the ***Schedule of Benefits***.

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

The Carrier periodically reviews the schedule of Covered Preventive Services as listed below under "Pediatric Preventive Care" and "Adult Preventive Care" based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society.

Accordingly, the frequency and eligibility of Covered Services are subject to change. A list of Preventive Care Covered Services can be found in the Preventive Schedule document. A complete listing of recommendations and guidelines can be found at https://www.healthcare.gov/preventive-care-benefits/.

The Carrier reserves the right to modify the Preventive Schedule document at any time after written notice of the change has been given to the Covered Person.

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

In addition to Office Visits a Covered Person 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 Carrier’s policies.

B. **Pediatric Preventive Care**
Coverage will be provided for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

C. **Immunizations**
Coverage will be provided for pediatric and adult immunizations (except those required for employment or travel), including the immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services. Pediatric and adult immunization schedules can be found in the Preventive Schedule document.

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

D. **Adult Preventive Care**
Coverage will be provided for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

E. **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.

F. **Women's Preventive Care**
Coverage will be provided 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. Covered Services include, but are not limited to, the following:

1. Routine Gynecological Exam, Pap Smear as described below.
2. Mammograms as described below.
3. Breastfeeding comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps from a Durable Medical Equipment supplier with medical necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Covered Person when provided by a Preferred Provider.
4. 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:
    a. Sterilization surgery for women;
    b. Surgical sterilization implant for women;
    c. Implantable rod;
    d. IUD copper;
    e. IUD with progestin;
    f. The shot or injection;
    g. Oral contraceptives (combined pill);
    h. Oral contraceptives (progestin only, and);
    i. Oral contraceptives (extended or continuous use);
    j. The contraceptive patch;
    k. Vaginal contraceptive rings;
    l. Diaphragm;
    m. Contraceptive sponges;
    n. Cervical caps;
    o. Female condoms;
    p. Spermicides;
    q. Emergency contraception (levonorgestrel); and

r. Emergency contraception (ulipristal acetate).

Although all FDA 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 Covered Person when provided by a Preferred Provider. Contraception drugs and devices are covered under this section of the Contract unless otherwise covered under the "Prescription Drugs/Medicines" paragraph of the "Outpatient Benefits" subsection of this Contract. Abortifacients are not considered contraceptives.

If a Covered Person's Physician determines that they require more than one well-women visit annually to obtain all recommended preventive services, the additional visit(s) will be provided without cost-sharing.

G. **Routine Gynecological Examination, Pap Smear**

Covered Persons are covered for one (1) routine gynecological examination each Benefit Period, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

H. **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.

I. **Osteoporosis Screening (Bone Mineral Density Testing or BMDT)**

Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method, in accordance with the Preventive Schedule document. 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.

J. **Nutrition Counseling**

Coverage will be provided for any Covered Person for nutrition counseling visits in an office setting, up to the Maximum visit limit as specified in the ***Schedule of Benefits***.

INPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services while an Inpatient in a Facility Provider when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and other cost-sharing requirements are specified in the ***Schedule of Benefits***.

A. **Hospital Services**

1. Ancillary Services

   Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including, but not limited to, the following:

   a. Meals, including special meals or dietary services as required by the Covered Person's condition;
   b. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
   c. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
   d. Oxygen and oxygen therapy;
   e. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;

f. Cardiac Rehabilitation Therapy, Chemotherapy, Dialysis, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation Therapy, Radiation Therapy, respiratory therapy, and Speech Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
g. All drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;
h. Use of special care units, including, but not limited to, intensive or coronary care; and
i. Pre-admission testing.

2. Room and Board
Benefits are payable for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:
a. An average semi-private room, as designated by the Hospital; or a private room, when designated by the Carrier as semi-private for the purposes of this Contract in Hospitals having primarily private rooms;
b. A private room, when Medically Necessary;
c. A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
d. A bed in a general ward; and
e. Nursery facilities.

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

A Copayment may apply to a Preferred Inpatient Admission, if specified in the ***Schedule of Benefits***. For purposes of calculating the total Copayment due, an admission occurring within ten (10) days of discharge from a previous admission shall be treated as part of the previous admission.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

Days available shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (a) during the absence of a Covered Person who interrupts their stay and remains past midnight of the day on which the interruption occurred; or (b) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

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

1. Concurrent Care
Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

2. Consultations
Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the

attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider's rules and regulations. Benefits are limited to one (1) consultation per consultant during any Inpatient confinement.

C. **Skilled Nursing Care Facility**
Benefits are provided for a Skilled Nursing Care Facility, when Medically Necessary as determined by the Carrier, up to the Maximum days specified in the ***Schedule of Benefits***. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility.

A Copayment may apply to a Preferred Inpatient Admission, if specified in the ***Schedule of Benefits***. For purposes of calculating the total Copayment due, an admission occurring within ten (10) days of discharge from a previous admission shall be treated as part of the previous admission.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

Days available shall be allowed only during uninterrupted stays in a Skilled Nursing Care Facility. Benefits shall not be provided: (a) during the absence of a Covered Person who interrupts their stay and remains past midnight of the day on which the interruption occurred; or (b) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the ***Schedule of Benefits***.

No Skilled Nursing Care Facility benefits are payable:
1. When confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;
2. For the treatment of Alcohol and Drug Abuse or dependency, and Mental Illness; or
3. After the Covered Person has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine custodial care.

INPATIENT/OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services either while an Inpatient in a Facility Provider or on an Outpatient basis when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and other cost-sharing requirements are specified in the ***Schedule of Benefits***.

A. **Blood**
Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage or transfusion - i.e., an individual having their own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for whole Blood, Blood plasma and Blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

B. **Hospice Services**
When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six (6) months or less and when the Covered

Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with a terminal illness rather than cure it. Hospice Care provides services to make the Covered Person as comfortable and pain-free as possible. When a Covered Person elects to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice Care at any time.

Respite Care: When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person's home. Up to seven (7) days of such care every six (6) months will be covered.

Benefits for Covered Hospice Services shall be provided until the earlier of the Covered Person's death or discharge from Hospice Care.

Special Hospice Services Exclusions: No Hospice Care benefits will be provided for:

1. Services and supplies for which there is no charge;
2. Research studies directed to life lengthening methods of treatment;
3. Services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
4. Care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

C. **Maternity/OB-GYN/Family Services**

1. Maternity/Obstetrical Care
   Services rendered in the care and management of a pregnancy for a Covered Person are a Covered Expense under this Contract as specified in the ***Schedule of Benefits***. Benefits are payable for: (a) facility services provided by a Hospital or Birth Center; and (b) professional services performed by a Professional Provider or certified midwife.

   Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the Carrier as provided for in the ***Managed Care*** section.

   A Copayment may apply to a Preferred Inpatient Admission, if specified in the ***Schedule of Benefits***. For purposes of calculating the total Copayment due, an admission occurring within ten (10) days of discharge from a previous admission shall be treated as part of the previous admission.

   In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

   In the event of early post-partum discharge from an Inpatient Admission, benefits are provided for Home Health Care as provided for in the Home Health Care benefit.

2. Elective Abortions
   Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Covered Person are a Covered Expense under this Contract.

3. Newborn Care
   The newborn child of a Covered Person shall be entitled to benefits provided by this Contract 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. To be eligible for Dependent coverage beyond the thirty-one (31) day period, the newborn child must be enrolled as a Dependent within such thirty-one (31) days.

4. Artificial Insemination
   Services performed by a Professional Provider for the promotion of fertilization of a recipient's own ova (eggs) by the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying simple sperm preparation, sperm washing and/or thawing.

D. **Mental Health/Psychiatric Care**
Benefits for the treatment of Mental Illness and Serious Mental Illness are based on the services provided and reported by the Provider. Upon request, the Carrier will make available the criteria for Medical Necessity determinations made under the Plan for Mental Health/Psychiatric Care to any current or potential Covered Person, Dependent or Preferred Provider. When a Provider renders Medical Care, other than Mental Health/Psychiatric Care, for a Covered Person with Mental Illness and Serious Mental Illness, payment for such Medical Care will be based on the Medical Benefits available and will not be subject to the Mental Health/Psychiatric Care limitations. Emergency Care will be considered Preferred Care.

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

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

2. Outpatient Treatment
   Benefits are provided for Outpatient treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be performed by a Preferred Professional Provider/Preferred Facility Provider.

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

   A Copayment may apply to a Preferred Inpatient Admission, if specified in the ***Schedule of Benefits***. For purposes of calculating the total Copayment due, an admission occurring within ten (10) days of discharge from a previous admission shall be treated as part of the previous admission.

3. Benefits are not payable for the following services:
   a. Vocational or religious counseling; and
   b. Activities that are primarily of an educational nature.

4. Benefit Period Maximums for Mental Health/Psychiatric Care
   All Inpatient Mental Health/Psychiatric Care for both Mental Illness and Serious Mental Illness are covered up to the Maximum day amounts per Benefit Period specified in the

Schedule of Benefits. Non-Preferred Benefit Period maximums are part of, not separate from, Preferred Benefit Period maximums.

E. **Routine Patient Costs Associated With Qualifying Clinical Trials**
Benefits are provided for Routine Costs Associated With Participation in a Qualifying Clinical Trial (see the ***Definitions*** section). To ensure coverage and appropriate claims processing, the Carrier must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Preferred Professional Provider, and in a Preferred Facility Provider, then the Carrier will consider the services by a Non-Preferred Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see ***Definitions*** section) by the Carrier.

F. **Surgical Services**
Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Also covered is: (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: (a) all stages of reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; (c) prostheses and physical complications all stages of mastectomy, including lymphedemas; and (d) 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.

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

1. <u>Hospital Admission for Dental Procedures or Dental Surgery</u>
Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure the Covered Person's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Contract will be covered during such a confinement.

2. <u>Oral Surgery</u>
Benefits will be payable for Covered Services provided by a Professional Provider and/or Facility Provider for:
   (a) Orthognathic surgery - surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
      (i) The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.
      (ii) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
      (iii) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to

non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.

(b) Other oral surgery - defined as surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Benefits will be provided only for:
   (i) surgical removal of impacted teeth which are partially or completely covered by bone;
   (ii) surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
   (iii) surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

To the extent that the Covered Person has available dental coverage, the Carrier reserves the right to seek recovery from the Provider.

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

3. Assistant at Surgery
   Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant at Surgery only if an intern, resident, or house staff member is not available.

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

4. Anesthesia
   Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider (except an Obstetrician providing Anesthesia during labor and delivery and an oral surgeon providing services otherwise covered under this Contract).

   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 Covered Persons age seven (7) or under and for developmentally disabled Covered Persons when determined by the Carrier 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.

5. Second Surgical Opinion (Voluntary)
   Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an emergency or life threatening nature. Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

G. **Transplant Services**
When a Covered Person is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants, which are beyond the Experimental/Investigative stage. Benefits, are also provided for those services to the Covered Person which are directly and specifically related to the covered transplantation.

This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of Blood provided to a Covered Person:

1. When both the recipient and the donor are Covered Persons, the payment of their respective medical expenses shall be covered by their respective benefit programs.
2. When only the recipient is a Covered Person, 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 this Program. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or coverage by the Carrier or any government program. When only the recipient is a Covered Person 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 this Program.
3. When only the donor is a Covered Person, the donor is entitled to the benefits of this Program for all related donor expenses, subject to the following additional limitations:
   a. The benefits are limited to only those benefits not provided or available to the donor from any other source for funding or coverage in accordance with the terms of this Program; and
   b. No benefits will be provided to the donor recipient.
4. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

H. **Treatment for Alcohol or Drug Abuse and Dependency**

Alcohol or Drug Abuse and dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal.

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and dependency provided by a Hospital or Facility Provider, subject to the Maximums shown in the ***Schedule of Benefits***, according to the provisions outlined below. For maximum benefits, treatment must be received from a Preferred Provider.

Upon request, the Carrier will make available the criteria for Medical Necessity determinations made under the Plan for Alcohol or Drug Abuse and Dependency to any current or potential Covered Person, Dependent or Preferred Provider.

1. Inpatient Treatment
   a. Inpatient Detoxification
      Covered Services include:
      (1) Lodging and dietary services;
      (2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
      (3) Diagnostic x-rays;
      (4) Psychiatric, psychological and medical laboratory testing;
      (5) Drugs, medicines, use of equipment and supplies.

      A Copayment may apply to a Preferred Inpatient Admission, if specified in the ***Schedule of Benefits***. For purposes of calculating the total Copayment due, an admission occurring within ten (10) days of discharge from a previous admission shall be treated as part of the previous admission.

   b. Hospital and Non-Hospital Residential Treatment
      Covered services include:
      (1) Lodging and dietary services;
      (2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
      (3) Rehabilitation therapy and counseling;
      (4) Family counseling and intervention;

(5) Psychiatric, psychological and medical laboratory testing;
(6) Drugs, medicines, use of equipment and supplies.

A Copayment may apply to a Preferred Inpatient Admission, if specified in the ***Schedule of Benefits***. For purposes of calculating the total Copayment due, an admission occurring within ten (10) days of discharge from a previous admission shall be treated as part of the previous admission.

2. Outpatient Treatment
   Covered services include:
   a. Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification by the appropriately licensed behavioral health Provider;
   b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
   c. Telebehavioral Health services;
   d. Rehabilitation therapy and counseling;
   e. Family counseling and intervention;
   f. Psychiatric, psychological and medical laboratory testing;
   g. Medication Management and use of equipment and supplies.

OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services on an Outpatient basis when deemed Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and other cost-sharing requirements are specified in the ***Schedule of Benefits***.

A. **Ambulance Services/Transport**
   Ambulance services, which Benefits are provided for ambulance services that are Medically Necessary as determined by the Carrier, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured are a Covered Expense, but only when:
   1. The Ambulance must be transporting the Covered Person: the vehicle is licensed as an ambulance where required by applicable law;
   2. From a Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital;
   3. Between Hospital and Skilled Nursing Facility or between Hospitals.

   If there is no Hospital in the local area that can provide services Medically Necessary for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.

   1. Air or sea ambulance transportation benefits the ambulance transport is appropriate for the patient's clinical condition;
   2. the use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would be contraindicated (i.e. would endanger the patient's health or be inappropriate for the patient's medical condition); and
   3. the ambulance transport satisfies the destination and other requirements stated below in either "For Emergency Ambulance transport" or "For Non-Emergency Ambulance transport".

   In addition, the Carrier 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 Covered Person and subsequently determines the Covered Person does not require transport or the Covered Person refuses to be transported. These services must be Medically Necessary as determined by the Carrier.

Benefits are payable for air or sea transportation only if the Carrier determines that the patient's condition, and the distance to the nearest facility able to treat the Covered Person's condition, justify the use of an alternative to land transport.

For Emergency Ambulance transport:
The Ambulance must be transporting the Covered Person from the Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital or other Emergency care Facility that can provide the Medically Necessary Covered Services for the Covered Person's condition.

For Non-Emergency Ambulance transport:
Non-emergency air or ground facility transport to the nearest appropriate facility that is capable of addressing the Covered Person's medical needs may be covered when Medically Necessary as determined by the Carrier (e.g. sending facility does not have the required services to effectively treat the Covered Person, such as trauma or burn care). Non-Emergency air or ground transport may be covered to transport the Covered Person to a Preferred Facility Provider as determined by the Carrier, when: (1) The transfer is Medically Necessary (as determined by the Carrier's definition of Medical Necessity); and (2) The Covered Person'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. Non-Emergency ambulance transports are not provided for family members or companions or for the convenience of the Covered Person, the family, or the Provider treating the Covered Person.

B. **Autism Spectrum Disorders**
The Carrier will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Covered Persons.

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed in accordance with either of the following:
1. 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.
2. 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.

Treatment of Autism Spectrum Disorders shall be identified in an ASD Treatment Plan and shall include any Medically Necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is:
1. Prescribed, ordered or provided by a licensed Physician, licensed Physician assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner;
2. Provided by an Autism Service Provider, including a Behavior Specialist; or
3. Provided by a person, entity or group that works under the direction of an Autism Service Provider.

An ASD Treatment Plan shall be developed by a licensed Physician or licensed Psychologist 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 Health Benefit Plan once every six months. A more or less frequent review can be agreed upon by the

Carrier and the licensed Physician or licensed Psychologist developing the ASD Treatment Plan.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed Physician or licensed Psychologist:

1. 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.
2. Pharmacy Care - Medications prescribed by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed physician assistant or Certified Registered Nurse practitioner to determine the need or effectiveness of such medications. If this Program provides benefits for Prescription Drugs the ASD medications may be purchased at a Pharmacy, subject to the cost-sharing arrangement applicable to the Prescription Drug coverage.
3. Psychiatric Care - Direct or consultative services provided by a Physician who specializes in psychiatry.
4. Psychological Care - Direct or consultative services provided by a Psychologist.
5. 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.
6. 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.
7. Therapeutic Care - Services provided by speech language pathologists, occupational therapists or physical therapists.

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:

1. Provide internal review followed by independent external review; and
2. Have levels, expedited and standard Appeal time frames, and other terms established by the Carrier 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 Member Services.

C. **Consumable Medical Supplies**

Benefits will be provided for the purchase of Consumable Medical Supplies when:

1. It is used in the Covered Person's home; and
2. It is obtained through a Professional Provider.

Consumable Medical Supplies Exclusions: any item that meets the following criteria is not a covered Consumable Medical Supply and will not be covered:

1. The item is for comfort or convenience.
2. 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, and toilet seats.
3. The item has features of a medical nature which are not required by the member's condition.
4. 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.

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

1. The Covered Person requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five (5) days per week for 4-7 hours per day;
2. The Covered Person has the ability to communicate (verbally or non-verbally) their needs; the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff;
3. The Covered Person is willing to participate in a Day Rehabilitation Program; and
4. The Covered Person's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

E. **Diabetic Education Program**
Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the Covered Person's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Preferred Facility Provider or a Preferred Ancillary Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Carrier. These requirements are based on the certification programs for Outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include Outpatient sessions that include, but may not be limited to, the following information:

1. Initial assessment of the Covered Person's needs;
2. Family involvement and/or social support;
3. Psychological adjustment for the Covered Person;
4. General facts/overview on diabetes;
5. Nutrition including its impact on blood glucose levels;
6. Exercise and activity;
7. Medications;
8. Monitoring and use of the monitoring results;
9. Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
10. Use of community resources; and
11. Pregnancy and gestational diabetes, if applicable.

F. **Diabetic Equipment and Supplies**
Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance requirements applicable to Durable Medical Equipment benefits, for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. Certain diabetic equipment and supplies, including insulin and oral agents, may be purchased at a Pharmacy, if available, subject to the cost-sharing arrangements applicable to the Prescription Drug coverage. Certain diabetic equipment 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.

1. Diabetic Equipment
   a. Blood glucose monitors;
   b. Insulin pumps;
   c. Insulin infusion devices; and
   d. Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

2. Diabetic Supplies
   a. Blood testing strips;
   b. Visual reading and urine test strips;
   c. Insulin and insulin analogs;
   d. Injection aids;
   e. Insulin syringes;
   f. Lancets and lancet devices;
   g. Monitor supplies;
   h. Pharmacological agents for controlling blood sugar levels; and
   i. Glucagon emergency kits.

G. **Diagnostic Services**

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

1. Routine Diagnostic Services, such as, but not limited to routine radiology (consisting of x-rays, mammograms, ultrasound, and nuclear medicine), routine medical procedures (consisting of ECG, EEG, and other diagnostic medical procedures approved by the Carrier), and allergy testing (consisting of percutaneous, intracutaneous and patch tests). Benefits are provided, without cost sharing when provided by a Preferred Provider, for diagnostic breast examinations because the Covered Person is believed to be at an average or increased risk of breast cancer.
2. Non-Routine Diagnostic Services, such as, but not limited to MRI/MRA, CT Scans, PET Scans and Nuclear Cardiology Imaging, and Sleep Studies. Benefits are provided, without cost sharing when provided by a Preferred Provider, for diagnostic breast examinations because the Covered Person is believed to be at an average or increased risk of breast cancer.
3. Diagnostic laboratory and pathology tests.
4. Benefits are provided for genetic testing and counseling. Genetic testing and counseling include services provided to a Covered Person at risk for a specific disease due to family history or because of exposure to environmental factors that are known to cause physical or mental disorders. When clinical usefulness of specific genetic tests has been established by the carrier, these services are covered for the purpose of diagnosis, screening, predicting the course of a disease, judging the response to a therapy, examining risk for a disease, or reproductive decision-making.

H. **Durable Medical Equipment**

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Carrier, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Necessary by the Carrier.

Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance. Durable Medical Equipment, as defined in the ***Definitions*** section, includes equipment that meets the following criteria:

1. It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical

supplies of an expendable nature are not considered "durable". (For examples, see item 4 under "Durable Medical Equipment Exclusions" below.)
2. It customarily and primarily serves a medical purpose.
3. It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the Covered Person's illness, injury, or to improvement of a malformed body part.
4. It is appropriate for home use.

Durable Medical Equipment Exclusions: Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:
1. **Comfort and convenience items,** such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.
2. **Equipment used for environmental control,** such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.
3. **Equipment inappropriate for home use.** This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, translift chairs and traction units.
4. **Non-reusable supplies** other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment.
5. **Equipment that is not primarily medical in nature.** Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to, Equipment for Safety, exercise equipment, speech teaching machines, strollers, toileting systems, electronically-controlled heating and cooling units for pain relief, bathtub lifts, stairglides, and elevators.
6. **Equipment with features of a medical nature** which are not required by the Covered Person's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.
7. **Duplicate equipment** for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.
8. **Services not primarily billed for by a Provider** such as delivery, set-up and service activities and installation and labor of rented or purchased equipment.
9. **Modifications to vehicles, dwellings and other structures.** This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Covered Person's disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as a wheelchair.

Replacement and repair: The Carrier will provide benefits for the replacement of Durable Medical Equipment when the equipment does not function properly and is no longer useful for its intended purpose in the following limited situations:
(a) When a change in the Covered Person's condition requires a change in the Durable Medical Equipment, the Carrier will provide repair or replacement of the equipment.
(b) When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Carrier will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Carrier.

If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contracts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of: (1) the Carrier in the case of rented equipment; and, (2) the Covered Person in the case of purchased equipment.

The Carrier will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty. For example, the Carrier will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

The Carrier will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage or defect.

I. **Emergency Care Services**

Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are provided by the Carrier at the Preferred level of benefits, regardless of whether the patient is treated by a Preferred or Non-Preferred Provider. If a Covered Person receives Emergency Care Services from a Non-Preferred Provider, the out of pocket expense will be no higher than if services were provided by a Preferred Provider. If Emergency Services are required, whether the Covered Person is located in or outside the Personal Choice Network service area, call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.

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

Examples of an Emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severe Accidental Injury, and other acute medical conditions as determined by the Carrier. Should any dispute arise, the Carrier determines as to whether an Emergency existed or as to the duration of an Emergency, subject to both the Member's option to appeal and appropriate regulatory authority and/or ruling by court of law.

J. **Habilitative Therapy Services**

Benefits shall be provided, subject to the Benefit Period Maximums specified in the ***Schedule of Benefits*** section of this Contract, for services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

1. Occupational Therapy
   Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

2. Physical Therapy
   Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part, including the treatment of functional loss following hand and/or foot surgery.

3. Speech Therapy
   Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

K. **Home Health Care**

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

1. Professional services of appropriately licensed and certified individuals;
2. Intermittent skilled nursing care;
3. Physical Therapy;
4. Speech Therapy;
5. Well mother/well baby care following release from an Inpatient maternity stay; and
6. Care within forty-eight (48) hours following release from an Inpatient Admission when the discharge occurs within forty-eight (48) hours following a mastectomy.

With respect to Item 5 above, one Home Health Care visit 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. At the mother's sole discretion, the initial Home Health Care visit may occur at the Facility of the Provider. No Coinsurance shall apply to the initial visit when provided after an early discharge from the Inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include Occupational Therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Carrier.

Home Health Care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Carrier as Medically Necessary.

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.

With the exception of Home Health Care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be Homebound in order to be eligible to receive Home Health Care benefits. For purposes of this Home Health care benefit, the following definitions apply:

HOME - means a Covered Person's place of residence (e.g. private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility (SNF) at a custodial level of care.

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

Home Health Care Exclusions: No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

1. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
2. Rental or purchase of Durable Medical Equipment;
3. Rental or purchase of medical appliances (e.g. braces) and Prosthetic Devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
4. Prescription drugs;
5. Services provided by a member of the Covered Person's Immediate Family;
6. Covered Person's transportation, including services provided by voluntary ambulance associations for which the Covered Person is not obligated to pay;

7. Emergency or non-Emergency Ambulance services;
8. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
9. Services provided to individuals (other than a Covered Person released from an Inpatient maternity stay), who are not essentially homebound for medical reasons; and
10. Visits by any Provider personnel solely for the purpose of assessing a Covered Person's condition and determining whether or not the Covered Person requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

L. **Injectable Medications**

Benefits will be provided for injectable medications required in the therapeutic treatment of an injury or illness, prescribed by a Professional Provider, and required for therapeutic use when determined to be Medically Necessary by the Carrier. The administration of injectable medications is determined by the dosage regimen of the medication and the Physician prescribed treatment plan.

1. Specialty Drugs

   Specialty Drugs refer to a medication that meets certain criteria including, but not limited to:
   a. The drug is used in the treatment of a rare, complex, or chronic disease;
   b. A high level of involvement is required by a healthcare provider to administer the drug;
   c. Complex storage and/or shipping requirements are necessary to maintain the drug's stability;
   d. The drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance;
   e. Access to the drug may be limited.

   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 listed on the back of your Identification Card. The purchase of all Specialty Drugs is subject to Copayment or Coinsurance amounts as shown in the ***Schedule of Benefits***.

   Gene Replacement Therapies are eligible for coverage under the medical benefit and require Precertification from the Carrier. The Carrier 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 Precertification list. This list can be found at: https://www.ibx.com/resources/for-providers/policies-and-guidelines/operations-management/preapproval-requirements.

   Copayment or Coinsurance amounts will apply: (a) to each thirty (30) day supply of medication dispensed for medications administered on a regularly scheduled basis; or (b) to each course/series of injections if administered on an intermittent basis.
   A ninety (90) day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness.

   Dual Coverage; coverage and costs: The Carrier will provide coverage for an injectable medication in accordance with Medical Policy coverage criteria and the terms and conditions of this Contract. This is subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements: (a) if the drug is covered under the "Injectable Medications" benefit of this Contract 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: Injectable

medications are subject to the cost-share specified in the ***Schedule of Benefits***; (b) 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 Covered Person can safely self-administer the drug without the assistance of a healthcare Provider, in accordance with the drug's prescribing information: Self-administered drugs are subject to the cost-sharing associated with the terms of the Covered Person's prescription drug benefit. Cost-sharing amounts for a drug that may be eligible for coverage under the Covered Person's medical benefit or prescription drug benefit may vary. Covered Persons should discuss these coverage options with their healthcare Provider. The Covered Person's financial responsibilities (including Deductible, Copayment, and/or Coinsurance) depend on the terms and conditions of the Covered Person's applicable benefit. These terms and conditions are subject to change.

2. Standard Injectable Drugs
   a. Standard Injectable Drugs refer to a medication that is either injectable or infusible but is not defined by the Carrier 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 Professional Provider.
   b. Self-Administered Prescription Drugs generally are not covered. For more information on Self-Administered Prescription Drugs, please refer to the ***Exclusions*** section.

M. **Medical Foods and Nutritional Formulas**

Medical Foods and Nutritional Formulas when administered orally are eligible for payment when provided through a Durable Medical Equipment supplier or in connection with the Infusion Therapy benefit as follows: 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 shall be 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-bowl 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 Durable Medical Equipment supplier or in connection with Infusion Therapy as provided for in this Contract.

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.

N. **Non-Surgical Dental Services**

Benefits will be provided only for the initial treatment of Accidental Injury/trauma, (i.e. fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, including the first caps, crowns, bridges and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury.

(See the exclusion of dental services in the ***Exclusions*** section for more information on what dental services are not covered.)

O. **Orthotics**

Benefits are provided for:

1. The initial purchase and fitting (per medical episode) of orthotic devices which are Medically Necessary as determined by the Carrier, except foot orthotics unless the Covered Person requires foot orthotics as a result of diabetes.
2. The replacement of covered orthotics for Dependent children when required due to natural growth.

P. **Prescription Drugs/Medicines**

After each Covered Person satisfies the Deductible amount, if any, for the Benefit Period, benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary and that are prescribed by a Physician and dispensed by a licensed retail Pharmacy*. Benefits for Prescription Drugs are available for a thirty (30) day supply, or the appropriate therapeutic limit, whichever is less, when dispensed from a retail Pharmacy. For prescriptions filled at a retail Non-Preferred Pharmacy, the Covered Person must pay the full retail price for their prescription then file a paper claim for reimbursement.

Benefits shall also be provided for covered Prescription Drugs prescribed for a chronic condition and ordered by mail if a Covered Person or the prescribing Physician submits to a Preferred Mail Order Pharmacy a written Prescription Drug Order specifying the amount of the covered Prescription Drug to be supplied. Benefits shall be available for up to a ninety (90) day supply of a covered Prescription Drug, subject to the amount specified in the Prescription Drug Order and applicable law. In addition, benefits shall also be provided for covered Prescription Drugs prescribed by a Physician for a chronic condition and dispensed by a designated retail Pharmacy or a participating Act 207 retail Pharmacy. The cost sharing indicated in the "Prescription Drugs" subsection of the ***Schedule of Benefits*** section for In-Network 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.

* If the Carrier determines Prescription Drug usage by any Covered Person appears to exceed usage generally considered appropriate under the circumstances, the Carrier shall have the right to direct that Covered Person to one Pharmacy for all future Prescription Drug Covered Services.

The Carrier will provide benefits for covered Specialty Drugs for the appropriate cost sharing for Preferred Pharmacies. Benefits are available for up to a 30-day supply**. No benefits shall be provided for Specialty Drugs obtained through a Non-Preferred 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 Covered Person's cost-share is prorated for each amount of the "split fill".

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

In certain cases, the Carrier may determine that the use of certain Prescription Drugs for a Covered Person's medical condition requires prior authorization for Medical Necessity. The Carrier also reserves the right to establish eligible dosage limits of certain Prescription Drugs covered by the Carrier.

Contraceptives, as described under the Women's Preventive Services provision of the Patient Protection and Affordable Act, covered under the Prescription Drugs/Medicines section of this Contract for certain generic products and brand products approved by the Federal Food and Drug Administration are covered at no cost-share to the Covered Person when obtained from a Preferred Pharmacy or Preferred Mail Order Pharmacy. Coverage includes oral and injectable contraceptives, diaphragms, cervical caps, rings and transdermal patches. The noted cost-sharing in the Prescription Drugs subsection of the ***Schedule of Benefits*** applies for all other contraceptive products.

For questions concerning:
A. Whether a particular Prescription Drug appears on the Drug Formulary; or
B. Pharmaceutical management procedures such as prior authorization requirements, prescription limits, use of generic substitution, therapeutic interchange or step therapy protocols and Copayment, Deductible and Coinsurance amounts;

The Covered Person may call the Member Services telephone number on the back of the Covered Person's Identification Card.

Information about criteria and how cost-share will be determined for formulary exceptions can be found in the Formulary Exception Policy, www.ibx.com/formularyexceptionspolicy. The Covered Person 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 Carrier will not transfer a Prescription Order from a Preferred Pharmacy to another Pharmacy unless requested by the Covered Person.

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

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

A. Prescription Drugs shall mean drugs or medications (including insulin):
    1. Which by law require a Prescription Order to dispense;
    2. Which are approved by the Carrier and approved for distribution by the federal government;
    3. For which Medical Necessity exists; and
    4. Which have been approved by the Federal Food and Drug Administration and only for those uses for which they have specifically been approved by the Federal Food and Drug Administration.

B. Benefits will not be payable for:
    1. Drugs not appearing on the Drug Formulary, except where an exception has been granted pursuant to the Formulary Exception Policy;
    2. Drugs used for Experimental/Investigative purposes;
    3. Health foods, dietary supplements or diet agents;
    4. Vitamins, unless they require a prescription and are Medically Necessary for the treatment of a specific illness, as determined by the Carrier;
    5. Drugs for which there is an equivalent that does not require a Prescription Order, (i.e. over-the-counter medicines), whether or not prescribed by a physician. This exclusion does not apply to insulin or over-the-counter drugs that are prescribed by a physician in accordance with applicable law and certain drugs that are specifically designated by the Carrier;
    6. Drugs which have no currently accepted medical use for treatment in the United States;

7. Drugs dispensed to a Covered Person while a patient in a Hospital, nursing home or other institution;
8. Administration or injection of drugs;
9. 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. This exclusion does not apply to: (a) devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin, (b) devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines, and (c) contraceptive devices as mandated by the Women's Preventive Services provision of the Patient Protection and Affordable Care Act;
10. Drugs used for cosmetic purposes, such as wrinkle removal or hair growth;
11. Drugs obtained through mail order prescription drug services of a Non-Preferred Mail Order Pharmacy;
12. Injectables used for the treatment of infertility when they are prescribed solely to enhance or facilitate conception;
13. Prescription Drugs not approved by the Carrier or prescribed drug amounts exceeding the eligible dosage limits established by the Carrier.

Q. **Prosthetic Devices**

Expenses incurred for Prosthetic Devices (except dental prostheses) required as a result of illness or injury.

Such expenses may include, but not be limited to:

1. The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device. 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;
3. Breast prostheses, pursuant to an order by the patient's physician, required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive surgery incident and subsequent to mastectomy.
4. Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
   a. Initial contact lenses prescribed for treatment of infantile glaucoma;
   b. Initial pinhole glasses prescribed for use after surgery for detached retina;
   c. Initial corneal or scleral lenses prescribed: (1) in connection with the treatment of keratoconus; or (2) to reduce a corneal irregularity other than astigmatism;
   d. Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
   e. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of: (1) Accidental Injury; (2) trauma; or (3) ocular surgery.

   Benefits are not provided for:
   a. Lenses which do not require a prescription;
   b. Mirror coatings;
   c. Deluxe frames; or
   d. Eyeglass accessories, such as cases, cleaning solution and equipment.

   The "Repair and Replacement" paragraphs set forth below do not apply to this item (4).

Benefits for replacement of a Prosthetic Device or its parts will be provided: (a) when there has been a significant change in the Covered Person's medical condition that requires the replacement; (b) if the prostheses breaks because it is defective; (c) if the prostheses breaks

because it exceeds its life expectancy, as determined by the manufacturer; or (d) for a Dependent child due to the normal growth process when Medically Necessary. However, the replacement requirements detailed in (a); (b); and (c) of this paragraph do not apply to the replacement of prosthetic devices required to replace a removed breast or portions thereof, pursuant to paragraph #3 above.

The Carrier will provide benefits to repair Prosthetic Devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of a prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Carrier will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

If a Prosthetic Device breaks and is under warranty, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

R. **Specialist Office/Telemedicine Visits**
Benefits will be provided for Specialist Service medical care provided in the office by a Provider other than a Primary Care Provider. For the purpose of this benefit, "in the office" includes medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

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 Contract’s policies.

S. **Spinal Manipulation Services**
Benefits shall be provided up to the limits specified in the ***Schedule of Benefits*** for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

T. **Rehabilitative Therapy Services**
Benefits shall be provided, subject to the Benefit Period Maximums specified in the ***Schedule of Benefits***, for the following services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

1. Occupational Therapy
Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

2. Physical Therapy
Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part, including the treatment of functional loss following hand and/or foot surgery.

3. Speech Therapy
   Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

U. **Therapy Services**
Benefits shall be provided, subject to the Benefit Period Maximums specified in the ***Schedule of Benefits***, for the following services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

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

2. Chemotherapy
   Benefits shall be provided for chemotherapy. Chemotherapy means 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:
   a. Drugs/biologics are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents;
   b. 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 Carrier's policies; and
   c. Drugs/biologics are eligible for coverage when they are injected or infused into the body by a Professional Provider.

3. Dialysis
   Benefits shall be provided for dialysis. The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

4. Infusion Therapy
   Benefits shall be provided for Infusion Therapy. Treatment includes 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 Covered Person. The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug Infusion or a Standard Injectable Drug Infusion, as determined by the Carrier.

5. 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.

6. Radiation Therapy
   Benefits shall be provided for Radiation Therapy. The treatment of disease by x-ray, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

7. 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.

V. **Urgent Care Center**
Benefits are provided for Urgent Care Centers, when Medically Necessary as determined by the Carrier. Urgent Care Centers are designed to offer immediate evaluation and treatment for health conditions that require medical attention in a non-emergency situation that cannot wait to be addressed by your Professional Provider or Retail Clinic. Cost-sharing requirements are specified in the ***Schedule of Benefits***.

W. **Virtual Care Services**

1. Services Provided by a contracted vendor
   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 ***Schedule of Benefits***. The Covered Person will pay the applicable cost-sharing via credit or debit card prior to the consultation.

2. Benefits Provided by Professional Provider
   Virtual care services are also covered, when provided by a Professional Provider and subject to the relevant cost-share applicable to that Provider. The Provider's eligibility will be determined by the Carrier in the Carrier's 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 Carrier's policies.

X. **Vision Care (Pediatric)**
This benefit is applicable to Covered Persons under the age of 19. All Vision Care benefits under this section end at the end of the month in which the Covered Person turns age 19.
1. Routine Eye Exam and Refraction
   Subject to the limits shown in the ***Schedule of Benefits***, benefits are payable for one (1) routine eye exam and refraction every Care Benefit Period.

2. Prescription Lenses and Frames or Contact Lenses from a Preferred Provider
   Subject to the limits shown in the ***Schedule of Benefits***, each Covered Person is entitled to the following benefits for vision frames and prescription lenses once every Benefit Period when provided by a Preferred Provider and the Covered Person 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.

   Frames and prescription lenses covered by this contract are limited to the Pediatric Frame Selection of covered frames and prescription lenses. The preferred provider will show the Covered Person the selection of frames and prescription lenses covered by this contract. If the Covered Person selects a frame or prescription lenses that are not included in the Pediatric Frame Selection covered under this Contract, the Covered Person is responsible for the difference in cost between the preferred 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 preferred 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.

A Covered Person who receives Vision Care (Pediatric) services from a Preferred Provider can elect to utilize a Non-Preferred Provider for related Vision Care (Pediatric) services on the recommendation or referral of the Preferred Provider, provided that the Preferred Provider gives to the Covered Person, prior to recommending, referring, prescribing or ordering any Vision Care (Pediatric) services from the Non-Preferred Provider, written notice that:

a. The Non-Preferred Provider is not a Preferred Provider.
b. The Covered Person has the option of selecting a Preferred Provider.
c. The Covered Person may have different financial obligations depending on whether the Vision Care (Pediatric) Provider is Preferred or Non-Preferred.

Vision Care (Pediatric) services received from a Non-Preferred Provider are not covered under this Contract.

3. Benefits are also provided for prescription contact lenses in lieu of eyeglasses, up to the limits shown in the ***Schedule of Benefits*** section of this Contract for Vision Care (Pediatric), once per Benefit Period.

4. Prescription Lenses and Frames or Contact Lenses from a Non-Preferred Provider
No benefits shall be provided for Prescription Lenses and Frames or contact lenses obtained from a Non-Preferred Provider.

Y. **Pediatric Dental Services**

An eligible Covered Person under nineteen (19) years of age is entitled to the Pediatric Dental Covered Services shown in the ***Schedule of Benefits*** when provided by a Participating Dentist. To find a Participating Dentist, the Covered Person can visit the Carrier's website or call the Customer Services telephone number on their Identification Card. Also, if agreed by the provider, Participating Dentists limit their charges for all services delivered to Covered Persons, even if the service is not covered for any reason and a benefit is not paid under this Contract. Services provided by a Non-Preferred Dentist are not covered under the Pediatric Dental Services benefit. Pediatric Dental Covered Services are subject to the provisions listed below and to the cost sharing listed in the ***Schedule of Benefits***.

PEDIATRIC DENTAL LIMITATIONS - Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age. All benefits under this Contract 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 (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 Covered Persons 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 Covered Persons 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.
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 eleven (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 IV 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). Thirty (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 Covered Person to the less costly treatment. However, if the Covered Person and the Dentist choose the more expensive treatment, the Covered Person 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 Carrier.

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 Covered Person's teeth or their supporting structures and,
   b) Restoring the Covered Person's oral structure to health and function.
2. Covered Persons 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.

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

1. Incurred prior to the Covered Person's Effective Date or after the Termination Date of coverage under this Contract.
2. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
3. For prescription and non-prescription drugs, vitamins or dietary supplements.
4. Cosmetic in nature as determined by the Carrier (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
5. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
6. 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 Insured Persons including newly adoptive children, regardless of age.
7. For diagnostic services and treatment of jaw joint problems by any method unless specifically covered under this Contract. 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.
8. For treatment of fractures and dislocations of the jaw.
9. For treatment of malignancies or neoplasms.
10. 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.
11. For replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
12. For periodontal splinting of teeth by any method.
13. For duplicate dentures, prosthetic devices or any other duplicative device.
14. For which in the absence of insurance the Covered Person would incur no charge.
15. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

16. For treatment and appliances for bruxism (night grinding of teeth).
17. For any claims submitted to the Carrier by the Covered Person or on behalf of the Covered Person in excess of twelve (12) months after the date of service.
18. 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).
19. 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.
20. For specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
21. Fees for broken appointments.
22. 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 Carrier will apply.
23. Orthodontic treatment is not a Pediatric Dental Covered Service unless deemed Medically Necessary and a written treatment plan is approved by the Carrier. Orthodontic services for the following are excluded:
    - Treatments that are primarily for Cosmetic reasons;
    - Treatments for congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment);
    - Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the ***Schedule of Benefits***. 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.

Predetermination

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

Review of a Benefit Determination

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

SECTION EX - EXCLUSIONS

Except as specifically provided in this Contract, no benefits will be provided for services, supplies or charges:

- Which are not Medically Necessary as determined by the Carrier for the diagnosis or treatment of illness or injury;

- Which are Experimental/Investigative in nature, except, as approved by the Carrier, Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Contract;

- Which were Incurred prior to the Covered Person's Effective Date of coverage;

- Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the "Benefits After Termination Of Coverage" subsection of this Contract;

- For any loss sustained or expenses Incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared;

- While a Covered Person is incarcerated in any adult or juvenile penal or correctional facility or institution;

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

- For which a Covered Person would have no legal obligation to pay;

- For Claims paid or payable by Medicare when Medicare is primary. For purposes of this Contract exclusion, coverage is not available for a service, supply or charge that is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits. The amount excluded for these claims will be either the amount "payable under Medicare" or the applicable plan fee schedule for the service, at the discretion of the Carrier;

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

- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;

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

- Which are not billed and performed by a Provider as defined under this Contract as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled:
  (a) "Habilitative Therapy Services";
  (b) "Rehabilitative Therapy Services";

(c) "Therapy Services" (that identifies covered Therapy Services as provided by licensed therapists); and
(d) "Ambulance Services/Transport"
of the ***Description of Benefits*** section of this Contract;

- Rendered by a member of the Covered Person's Immediate Family;

- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;

- For ambulance services/transport except as specifically provided in the Ambulance Services/Transport benefit as specified in the ***Description of Benefits*** section of this Contract;

- For services and supplies provided in conjunction with procedures that are determined to be cosmetic under the Contract. A procedure is "cosmetic" if it is designed to improve the appearance of any portion of the body, but is not expected to produce any significant improvement in physiologic function. This "cosmetic" exclusion does not apply to covered surgical procedures performed for: (a) newborns within the first thirty-one (31) days after birth, and beyond that period if continuously covered under this Contract, for care and treatment of medically diagnosed congenital defects or birth abnormalities; (b) reconstructive surgery after mastectomy as required by law; (c) reconstructive surgery performed for the purpose of approximating or restoring original physical appearance from: (1) anomalies caused by an accidental injury; or (2) anomalies caused by previous surgery or other medical intervention to treat illness or disease; or (d) cosmetic procedures necessitated by a covered illness or injury.

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

- For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, naturopathy, hypnotherapy, bioenergetic therapy, Qi Gong, Ayurvedic therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;

- For marriage counseling;

- For Custodial Care, domiciliary care or rest cures;

- For equipment costs related to services performed on high cost technological equipment as defined by the Carrier, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Carrier;

- For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentiogenesis 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 Contract. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of

periodontal disease unless otherwise indicated. This exclusion does not apply to dental services provided for the initial treatment of an Accidental Injury/trauma;

- For dental implants for any reason;
- For dentures, unless for the initial treatment of an Accidental Injury/trauma;
- For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;
- For injury as a result of chewing or biting (neither is considered an Accidental Injury);
- For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;
- For routine foot care, as defined in the Carrier'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;
- For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes, except for orthotics or podiatric appliances required for the prevention of complications associated with diabetes;
- For 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;
- For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
- For sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist;
- For treatment of obesity, including surgical treatment of obesity and pharmacological drugs for the treatment of obesity management. This exclusion does not apply to nutrition counseling visits/sessions as described in the "Nutrition Counseling" provision under the ***Description of Benefits*** section of this Contract;
- 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;
- As described under "Durable Medical Equipment" in the ***Description of Benefits*** section, for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the Covered Person's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicated equipment, whether or not rented or purchased as a convenience; and devices and equipment used for environmental control; and customized wheelchairs;
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated in this Contract;

- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

- For Orthoptic/Pleoptic therapy;

- For preventive services except as specifically provided for in the Primary and Preventive Care subsection in the ***Description of Benefits*** section of this Contract;

- For weight reduction and premarital blood tests;

- For preventive screening examinations, except for mammograms and those screening examinations listed under "Pediatric Preventive Care", "Adult Preventive Care", "Women's Preventive Care", and "Diagnostic Services" in the ***Description of Benefits*** section of this Contract;

- For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;

- For immunizations required for employment purposes or travel;

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

- For care in a: (a) long term care facility, including a: (1) nursing home; (2) assisted living facility; and (3) board and care home; (b) continuing care retirement facility; (c) convalescent home; (d) school, with the exception of behavioral health services specified in the Carrier's Medical Policies; (e) camp, with the exception of behavioral health services specified in the Carrier's Medical Policies; or (f) institution for intellectually disabled children;

- For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided or allowed in the "Treatment for Alcohol or Drug Abuse and Dependency" or "Transplant Services" sections of the ***Description of Benefits***;

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

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

- For medication other than Prescription Drugs unless such medication is administered on an Inpatient basis;

- For Prescription Drugs used for Experimental/Investigative purposes, or Prescription Drugs prescribed or used for cosmetic purposes (such as hair growth or wrinkle removal, etc.);

- 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, and 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 benefit in the ***Description of Benefits*** section of this Contract;

- 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);

- For Inpatient and Outpatient Private Duty Nursing services;

- For charges Incurred for expenses in excess of Benefit Maximums as specified in the ***Schedule of Benefits*** of this Contract;

- For research studies;

- 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 injury caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy);

- For Self-Administered Prescription Drugs, 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:
  (a) Covered under the "Prescription Drugs/Medicines" subsection of the ***Description of Benefits*** section of this Contract;
  (b) Mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes; or
  (c) Required for treatment of an emergency condition that requires a Self-Administered Drug;

- For Convenience Pack drugs which combine two or more individual drug products into a single package with a unique national drug code;

- For Liposuction (Suction-Assisted Lipectomy) for the treatment of lipedema. This exclusion does not apply to: (a) Liposuction (Suction-Assisted Lipectomy) for the treatment of lipedema when the Carrier: (1) Determines the Liposuction (Suction-Assisted Lipectomy) is Medically Necessary; and (2) 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);

- 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 eighteen (18) months after the accelerated approval.**

  Monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease (e.g., aducsnumab-avwa)

  Delandistrogene moxeparvovec

Tofersen

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

Lecanemab-irmb (Leqembi)

- 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.

- For any other service or treatment except as provided in this Contract.

SECTION GP - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES
This Contract, Preventive Schedule, applicable endorsements, Identification Cards, Premium Rate Notification Letter, and attached papers, if any, comprise the entire Contract between the Applicant and the Carrier. No change in this Contract will be effective until approved by an authorized officer of the Carrier. This approval must be noted on or attached to this Contract. No agent or representative of the Carrier, other than an officer of the Carrier may otherwise change this Contract or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES
After three (3) years from the date of issue of this Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a 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 Contract 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 Contract.

GRACE PERIOD
This Contract has a grace period of thirty (30) days. If a payment is not made on or before the date it is due, it may be paid during the grace period. The Contract will stay in force during the grace period, unless prior to the date payment was due, the Applicant-Subscriber gave timely written notice to the Carrier that the Contract is to be cancelled. During the grace period, the Carrier will pay all appropriate claims. If premiums are not paid by the end of the grace period, this Contract automatically terminates on the last day of the grace period, subject to the "Benefits After Termination Of Coverage" provisions set forth in this section and the Carrier will have no liability for services which are Incurred after the grace period. The Carrier has the right to collect all outstanding premiums, including the premium for the grace period, from the Applicant-Subscriber.

REINSTATEMENT
If this Contract is terminated due solely to nonpayment of the premium, coverage will be reinstated if the Applicant, within 30 days from the date the Grace Period ends, applies for reinstatement and the Carrier receives payment of the premium required for 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. The Carrier and Covered Persons have the same rights under the reinstated Contract as they had under the Contract immediately before the due date of the defaulted premium.

If the Contract is not reinstated according to the provisions above, the Applicant may apply for a new Contract. Upon acceptance of the Application by the Carrier, the Applicant and eligible Dependents shall be subject to all the terms of the new Contract.

LEGAL ACTIONS
No action at law or in equity may be taken to recover benefits prior to the expiration of sixty (60) days after written proof of loss has been given in accordance with the requirements of this Contract, and no such action may be taken later than three (3) years after the date written proof of loss is required to be furnished.

EFFECTIVE DATE AND TERM
This Contract shall be effective from the date of this issuance, as that date appears on the records of the Carrier for a term of one (1) year and annually thereafter upon payment and acceptance by the Carrier of the premium due; and upon compliance with the terms and provisions of this Contract, or any renewal thereof. The Carrier will provide written confirmation

of the Applicant's Effective Date on the application form and the Schedule of Rates sent to the Applicant following acceptance by the Carrier of the premium due.

Subject to the right of the Carrier to terminate coverage and to any amendment permitted under applicable law, this Contract will remain in effect continually until terminated by the Covered Person or the Carrier in accordance with "Termination of the Contract" provisions as detailed in this ***General Provisions*** section.

At the time of coverage renewal, the Carrier may modify the health insurance coverage for this Contract form offered to individuals in the individual market so long as such modification is consistent with Pennsylvania law and effective on a uniform basis among all individuals covered under this Contract form.

BENEFITS TO WHICH COVERED PERSONS ARE ENTITLED

1. The benefit liability of the Carrier is limited to the benefits specified in this Contract.
2. Except as may be provided under the Transplant Services benefit of the ***Description of Benefits*** section of this Contract, no person other than a Covered Person (or a newborn child within the first 31 days of birth) is entitled to receive benefits under this Contract. Such right to benefits and coverage is not transferable, except where necessary in the case of a custodial parent of a Dependent covered under this Contract, if required by law.
3. Benefits for Covered Services specified in this Contract will be provided only for services and supplies that are rendered by a Provider specified in the ***Definitions*** section of this Contract.

TERMINATION OF THE CONTRACT

The Applicant may renew this Contract annually on the Anniversary Date except the Carrier can make a determination not to renew the Contract for nonpayment of the required premium, fraud or intentional misrepresentation of a material fact. The Carrier can determine not to renew the Contract if the Applicant does not reside in the geographical area served by the Carrier. Should the Applicant reside in a geographic area outside the area served by the Carrier and he wishes to continue coverage, the Covered Person must transfer their coverage to the Blue Cross and Blue Shield plan that serves the area.

Nonrenewal shall not be based on any health status-related factors of a Covered Person. With respect to relocation outside the geographic area covered by the Carrier, the Covered Person will be given thirty (30) days advance notice of any decision not to renew.

The Carrier can also non-renew this Contract form for all enrolled persons. In such case, the Carrier will provide notice to each Covered Person at least ninety (90) days prior to the date of discontinuation of such coverage. Such notice will provide enrolled persons with the option to purchase, without proof of insurability, any other individual health insurance coverage currently offered by the Carrier.

The Carrier can also non-renew this Contract because it elects to discontinue offering all health insurance coverage in the individual market in Pennsylvania. In such case the Carrier will provide notice to all enrolled persons and the Pennsylvania Insurance Department of such discontinuation at least 180 days prior to the date of the expiration of the coverage.

CHANGE IN STATUS AND CHARGES

1. <u>Adding a Dependent spouse</u>:
   An Applicant can apply to enroll a Dependent spouse for coverage under this Contract provided that the Applicant submits the Application to the Carrier for addition of the Dependent spouse. The Effective Date of Coverage for such Dependent spouse will be the

first billing date following thirty (30) days after such Application is accepted by the Carrier and timely payment of the appropriate rate has been made.

2. Adding a Dependent child:
   A newborn child of a Covered Person shall be entitled to benefits provided by this Contract from the date of birth up to a maximum of thirty-one (31) days. To be eligible for Dependent coverage beyond the thirty-one (31) day period, the Applicant must enroll the newborn child as a Dependent within such thirty-one (31) days and make timely payment of the appropriate rate, calculated from the 32nd day after birth.

   An adopted child of the Covered Person shall be entitled to benefits provided by this Contract from the date of placement for adoption up to a maximum of thirty-one (31) days. This coverage will be effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. To be eligible for Dependent coverage beyond the thirty-one (31) days period, the Applicant must enroll the adopted child as a Dependent within such thirty-one (31) days and make timely payment of the appropriate rate, calculated from the 32nd day after birth.

   Except for a newborn child or adopted child, a newly acquired Dependent child shall be eligible for coverage under this Contract provided that the Applicant makes Application to the Carrier 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 Carrier 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 Contract no later than thirty (30) days from receipt of the Carrier of the court order, provided the Carrier receives a completed Application and is accepted by the Carrier.

3. Death of Applicant
   In the event of the death of the Applicant, that coverage for Applicant shall terminate at the end of the last period for which payment was accepted by the Carrier. The spouse of the deceased Applicant, if covered under this Contract, shall become the Applicant and eligible Dependents will continue as the Applicant's Dependents under this Contract.

4. Divorce of Dependent Spouse
   If a Dependent spouse is divorced from the Applicant, coverage of such Dependent spouse under this Contract shall terminate at the end of the last period for which payment was accepted by the Carrier. The terminated spouse may apply for a new direct pay coverage, without proof of insurability, by applying within sixty (60) days of such termination. The direct pay coverage will be the same coverage, or one that nearly approximates the coverage of this Contract, if this contract form is no longer offered by the Carrier, and will be effective on the date that coverage terminated under the prior coverage at the rate then in effect.

5. 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 direct pay coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This direct pay coverage may be different from the coverage provided under this Contract.

6. Dependent Child's Attainment of Age Twenty-six (26)
   The eligibility of a Dependent child will terminate on the 1st day of the contract month following the occurrence of such Dependent's attainment of age twenty-six (26).

In addition, 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 (1) year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. However, the limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.

Extension of Eligibility for Students on Military Duty

The limiting age of twenty-six (26) does not apply to a full-time student who is eligible for coverage under this Contract 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 thirty (30) or more consecutive days; or
B. A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of thirty (30) or more consecutive days.

Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty. As proof of eligibility, the enrolled Applicant must submit a form to the Carrier approved by the Department of Military & Veterans Affairs (DMVA):

A. Notifying the Carrier that the Dependent has been placed on active duty;
B. Notifying the Carrier that the Dependent is no longer on active duty; or
C. Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting sixty (60) or more days after their release from active duty.

The coverage for such child will terminate at the end of the last period for which premium was accepted by the Carrier. No premium shall be accepted under this Contract on behalf of a child for any period for which such child is not an eligible Dependent. However, in the event the Carrier 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.

7. 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 Carrier to continue coverage of such child under this Contract 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.

BENEFITS AFTER TERMINATION OF COVERAGE

If coverage is cancelled or not renewed by the Carrier:

1. Except for non-payment of premium, coverage will be continued with respect to a pregnancy which commenced while the Contract was in force and for which benefits would have been paid had the Contract continued in force.
2. With respect to a Covered Person who is continuously disabled, coverage will be continued without prejudice to any continuous loss which commenced while the Contract was in force.

Continuation of coverage will continue, subject to all benefit Maximums, until the earlier of: (a) the end of the disability; or (b) the end of the current Benefit Period.

RELEASE OF INFORMATION
Each Covered Person agrees that any person or entity having information relating to an illness or injury, for which benefits are claimed under this Contract, may furnish to the Carrier, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Carrier may furnish similar information to other entities providing similar benefits at their request.

The Carrier may also furnish other Carriers or Carrier sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Carrier needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Carrier will obtain consent from a parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP
1. The choice of a Provider is solely the Covered Person's.
2. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by Covered Persons. The Carrier is not liable for any act or omission of any Provider. The Carrier has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.
3. The use or non-use of an adjective such as Preferred or Non-Preferred in modifying any Facility Provider or Professional Provider is not a statement as to the ability of the Facility Provider or the Professional Provider.

IDENTIFICATION CARDS
The Carrier will provide Identification Cards to all Covered Persons.

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

NOTICE
Any notice required under this Contract must be in writing. Notice given to the Covered Person will be sent to the Covered Person's address stated in the Application. Notice given to the Carrier will be sent to Independence Blue Cross, of which QCC Insurance Company is an affiliate, at the address stated in the Application. Notice given to a Covered Person will be sent to the Covered Person's address as it appears on the records of the Carrier. The Covered Person may, by written notice, indicate a new address for giving notice.

COORDINATION OF BENEFITS

All benefits, except the Vision Care and Pediatric Dental Services benefits, provided under this Contract are subject to this provision, and will not be increased by virtue of this provision.

A. Definitions - In addition to the Definitions of this Contract, the following definitions apply only to this provision;
    1. "Plan" means any individual coverage or group arrangement providing health care benefits or Covered Services through:
        a. individual, group (except hospital indemnity plans), blanket (except student accident) or franchise insurance coverage;
        b. Blue Cross, Blue Shield, health maintenance organization and other prepayment coverage;

c. coverage under labor-management trust plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
d. coverage under any tax supported or government program to the extent permitted by law.

"Plan" 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 benefits or services of Plans into consideration in determining its benefits and that portion which does not.

2. "Dependent" means, for any Plan, any person who qualifies as a Dependent under that Plan.
3. "Allowable Benefits" means the charge for Covered Services.
4. "Benefits Paid or Payable" means amounts actually paid for Covered Services.

B. Effect on Benefits
1. This provision shall apply in determining the benefits of this Contract if, for Covered Services received, the sum of the Benefits Payable under this Contract and the Benefits Payable under other Plans would exceed the Allowable Benefits.
2. Except as provided in item 3. of this Section, the Benefits Payable under this Contract for Covered Services will be reduced so that the sum of the reduced benefits and the Benefits Payable for Covered Services under other Plans does not exceed the total of Allowable Benefits.
3. If,
   a. the other Plan contains a provision coordinating its benefits with those of this Contract and its rules require the benefit of this Contract to be determined first, and
   b. the rules set forth in item 5 of this Section require the benefits of this Contract to be determined first,

   then the benefits of the other Plan will be ignored in determining the benefits under this Contract.
4. If the other Plan does not include a Coordination of Benefits provision, such plan will be the primary Plan.
5. If the other Plan does include a Coordination of Benefits provision:
   a. The Plan covering the patient other than as a Dependent will be the primary Plan.
   b. Where both Plans cover the patient as a Dependent child, the Plan covering the patient as a Dependent child of a parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be the primary Plan. But, if both parents have the same birthday, the Plan which covered the parents longer will be the primary Plan. If the parents are separated or divorced the following will apply:
      (i) The Plan which covers the child as a Dependent of the parent with custody will be the primary Plan.
      (ii) If the parent with custody has remarried, the Plan which covers the child as a Dependent of the stepparent with custody will determine its benefits before the Plan covering the child as Dependent of the parent without custody.
      (iii) Where there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child, the Plan which covers the child as a Dependent of the parent with such financial responsibility will be the primary Plan as long as the Plan of that parent has actual knowledge of the court decree.
      (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in the first paragraph of B.5.(b).

C. Facility of Payment - When payments should have been made under this Contract in accordance with the provision, but the payments have been made under any other Plan, this Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid shall be

deemed to be benefits paid under this Contract and to the extent of the payments for covered services, the Plan shall be fully discharged from liability under this Contract.

D. Right of Recovery
   1. Whenever payments have been made by this Plan for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, this Plan shall have the right to recover the excess from among the following, as the Carrier shall determine: any person to or for whom such payments were made, any insurance companies, or any other organizations.
   2. The Applicant and the Carrier will cooperate fully to make every reasonable effort, under the circumstances, to help secure the Carrier's rights to recover these excess payments.

E. The Carrier shall not be required to determine the existence of any plan or amount of Benefits Payable under any plan except this Contract, and the payment of benefits under this Contract shall be affected by the Benefits payable under any and all other plans only to the extent that the Carrier is furnished with information relative to such other plans by any other insurance company or organization in person.

   When the benefits are reduced under the primary Plan because the Applicant does not comply with the Contract provisions, the amount of such reduction will not be considered an Allowable Benefit. Examples of such provisions are those related to second surgical opinions and Precertification of certain healthcare services.

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, you agree that the Carrier 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 Carrier pays benefits on behalf of a Covered Person and the Covered Person 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 Carrier is subrogated to the Covered Person's right to recover from the Responsible Third Party. This means that the Carrier "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 Carrier 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 Covered Person obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Covered Person must fully reimburse the Carrier for all medical expenses that were paid to the Covered Person or on the Covered Person's behalf out of the amounts recovered from the Responsible Third Party to the extent permitted by law. The Carrier 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 Covered Person, including amounts recovered under an uninsured or underinsured motorist policy.
- The Carrier 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 Carrier agrees to do so in writing.
- In addition to any Coordination of Benefits rules described in this Contract, the benefits paid by the Carrier 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 Covered Person 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 Covered Person.
- The Carrier 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 Covered Person

- Immediately notify the Carrier 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 Carrier 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 Carrier or its delegated representative.
- Fully cooperate with the Carrier 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 Carrier's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Carrier 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 Covered Person.

PAYMENT OF PROVIDERS

A. Preferred Provider Reimbursement

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

Please note that these programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. For questions about how a health care Provider is compensated, the Covered Person is advised to speak with the healthcare Provider directly or contact the Carrier's Member Services Department at the telephone number shown on the back of the Identification Card.

1. Physicians

Personal Choice Network Physicians, including primary care Physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according

to the Carrier's Personal Choice fee schedule for the specific medical services that the Physician performs.

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

      The Carrier has implemented a quality incentive program with a few of the Network Hospitals. This program will provide increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors.

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

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

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

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

5. Pharmacy Providers
   The Carrier 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 its customers. Under some circumstances, the

Carrier may use a portion of the rebates received from its PBM to lower the drug price used for purposes of determining what the Covered Person should pay based on Covered Person benefits at the time a rebatable drug is dispensed to the Covered Person at a Preferred Pharmacy. Expected Prescription Drug rebates are based on historical drug rebates received by the Carrier 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 Carrier's PBM. While the Carrier 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 Carrier's control. The customer acknowledges that any rebate amounts beyond amounts that are passed on to the customer are for the sole benefit of the Carrier and that neither the customer, nor anyone else is entitled to receive any portion of such savings whether as part of any claims settlement or otherwise.

B. Payment of Non-Preferred Providers

For Covered Services received from a Non-Preferred Provider when the Consolidated Appropriations Act (“CAA”) does not apply the the Covered Services, payment will be made directly to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Provider. However, the Carrier reserves the right, in its sole discretion, to make payments directly to the Non-Preferred Provider. For Covered Services that fall within the scope of the CAA, payment will be made directly to the Non-Preferred Provider in accordance with the provisions of the CAA.

C. Payment Methods

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

1. Facility Providers

Preferred Facility Providers

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

Non-Preferred Facility Providers

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

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

If the Carrier determines that Covered Services were for Emergency Care as defined herein, the Covered Person is protected from surprise billing or balance billing. The

Covered Person cannot be balanced billed for the Emergency Services. This includes services the Covered Person may receive after the Covered Person is in stable condition, unless the Covered Person gives written consent and gives up the right under the CAA not to be balanced billed for these post-stabilization services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Carrier. Payment for Emergency Services provided by Non-Preferred Providers will be based upon the methodology established by the CAA.

Emergency Care by Non-Preferred Facility Providers
If the Carrier determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person is protected from surprise billing or balance billing and will be subject to the Preferred cost sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. **In no circumstance shall the Covered Person be liable for a greater out of pocket expense than if they had been attended to by a Preferred Provider.** The Covered Person cannot be balanced billed for the Emergency Services. This includes services the Covered Person may receive after the Covered Person is in stable condition, unless the Covered Person gives written consent and gives up the right under the CAA not to be balanced billed for these post-stabilization services.

For Emergency Care and other Non-Preferred Providers, such as ambulance and air ambulance services, the Carrier will reimburse the Non-Preferred Provider directly for Covered Services based upon the methodology established by the CAA. Payment for emergency services provided by Non-Preferred Providers will be based upon the methodology established by the CAA.

For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of "Covered Expense" in the ***Definitions*** section of this Contract. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Carrier.

2. Professional Providers

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

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

Once Covered Services are rendered by a Professional Provider, the Carrier will not honor a Covered Person's request not to pay for claims submitted by the Professional

Provider. The Carrier will have no liability to any person because of its rejection of the request.

Emergency Care by Non-Preferred Professional Providers
If the Carrier determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person is protected from surprise billing or balance billing and will be subject to the Preferred cost sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. **In no circumstance shall the Covered Person be liable for a greater out of pocket expense than if they had been attended to by a Professional Provider.** The Covered Person cannot be balanced billed for the Emergency Services. This includes services the Covered Person may receive after the Covered Person is in stable condition, unless the Covered Person gives written consent and gives up the right under the CAA not to be balanced billed for these post-stabilization services.

For Emergency Care and other Non-Preferred Providers, such as ambulance and air ambulance services, the Carrier will reimburse the Non-Preferred Provider directly for Covered Services based upon the methodology established by the CAA. Payment for emergency services provided by Non-Preferred Providers will be based upon the methodology established by the CAA.

For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of "Covered Expense" in the ***Definitions*** section of this Contract. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Carrier.

Non-Preferred Hospital-Based Provider Reimbursement
When the Covered Person receives Covered Services from a Non-Preferred Hospital-Based Provider while the Covered Person is an Inpatient at a Preferred Hospital or other Preferred Facility Provider and is being treated by a Preferred Professional Provider, the Covered Person will receive the Preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For Covered Services outside the scope of the CAA, payment will be made to the Covered Person, who will be responsible for reimbursing the Non-Preferred Hospital-Based Provider. For such Covered Services within the scope of the CAA, the Carrier will reimburse the Non-Preferred Hospital-Based Provider directly based upon the methodology established by the CAA. **In no circumstance shall the Covered Person be liable for a greater out of pocket expense than if they had been attended to by a Preferred Provider.** The Covered Person cannot be balanced billed by the Non-Preferred Hospital-Based Provider, and the Non-Preferred Hospital-Based Provider cannot ask the Covered Person to give up their right under the CAA not to be balanced billed.

If the Covered Person receives other services at a Preferred Hospital or other Preferred Facility Provider, Non-Preferred Providers cannot balance bill the Covered Person, unless the Covered Person gives written consent and gives up the right under the CAA not to be balanced billed.

Note that when the Covered Person elects to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where the Covered Person has the ability to select a Preferred Provider and the CAA does not apply to the Covered Service, the Covered Services will be covered at a Non-Preferred benefit level.
Except for Emergency Care, if a Non-Preferred Provider admits the Covered Person to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Hospital Based Provider.

Payment for services provided by Non-Preferred Hospital-Based Providers will be based upon the methodology established by the CAA. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of "Covered Expense" in the ***Definitions*** section of this Contract.

Inpatient Hospital Consultations by a Non-Preferred Professional Provider
When the Covered Person receives Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while the Covered Person is an Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, the Covered Person will receive the Preferred cost-sharing level of benefits for the Inpatient hospital consultation. The Carrier will reimburse the Non-Preferred Professional Provider at a Preferred rate directly. For certain Non-Preferred Hospital-Based Providers (For example, anesthesiologists, hospitalists and other Providers as defined by the CAA), the Carrier will reimburse the Non-Preferred Hospital-Based Provider directly based upon the methodology established by the CAA. For certain Providers, the Covered Person cannot be balanced billed by the Non-Preferred Professional Provider, and the Non-Preferred Professional Provider cannot ask the Covered Person to give up their right under the CAA not to be balanced billed. **In no circumstance, shall the Covered Person be liable for a greater out of pocket expense than if they had been attended to by a Preferred Provider.** For such Covered Services not within the scope of the CAA, payment will be made to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Professional Provider. For Covered Services within the scope of the CAA, payment for consultation services provided by Non-Preferred Professional Providers will be made directly to the Provider based upon the methodology established by the CAA.

The Non-Preferred Professional Provider cannot balance bill the Covered Person, unless the Covered Person gives written consent and gives up the right under the CAA not to be balanced billed.

Note that when the Covered Person elects to see a Non-Preferred Professional Provider for follow-up care or any other service when the Covered Person has the ability to select a Preferred Provider, and the CAA does not apply to the Covered Service, the Covered Services will be covered at a Non-Preferred benefit level.
Except for Emergency Care and other Covered Services within the scope of the CAA, if a Non-Preferred Professional Provider admits the Covered Person to a Hospital or other Facility Provider, services provided by a Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Covered Person and the Covered Person will be responsible for reimbursing the Non-Preferred Professional Provider.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of "Covered Expense" in the ***Definitions*** section of this Contract.

Non-Preferred Air Ambulance Providers
For air ambulance services provided by a Non-Preferred Provider, the Covered Person is protected from surprise billing or balance billing and will be subject to the Preferred cost-sharing levels. Penalties that ordinarily would be applicable to Non-Preferred Covered Services will not be applied. The Carrier will reimburse the Non-Preferred Provider directly based upon the methodology established by the CAA. In this instance the specified Non-Preferred Provider will not bill the Covered Person for amounts in excess of the Carrier's payment for air ambulance services and the Covered Person cannot be balanced billed for the air ambulance services provided by a Non-Preferred Provider. Payment for air ambulance services provided by Non-Preferred Providers, will be based upon the methodology established by the CAA.

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

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

3. Ancillary Providers and Pharmacies

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

   Preferred Pharmacies
   Preferred Pharmacies are members of the Carrier's Pharmacy Benefit Manager's network. This network of pharmacies has a contractual relationship with the Carrier for the provision of Pharmacy services at the Preferred level of benefits to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** of this Contract for the provision of Prescription Drugs provided to Covered Persons by Preferred Pharmacies. The Carrier's Pharmacy Benefits Manager will compensate Preferred Pharmacies in accordance with the contracts entered into between such Pharmacies and the Pharmacy Benefits Manager. Preferred Pharmacies will make no additional charge to Covered Persons for covered prescription drugs, except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this Contract.

   b. Non-Preferred Ancillary Providers/Non-Preferred Pharmacies
   Non-Preferred Ancillary Providers and Non-Preferred Pharmacies are not members of the Personal Choice Network. Benefits will be provided to the Covered Person at the Non-Preferred Coinsurance level specified in the ***Schedule of Benefits*** of this Contract. The Covered Person will be penalized by the application of a higher cost sharing as detailed in the ***Schedule of Benefits*** of this Contract. For payment of Covered Services provided by a Non-Preferred Ancillary Provider or Non-Preferred Pharmacy, please refer to the definition of "Covered Expense" in the ***Definitions*** section of this Contract. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider or Pharmacy, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider or the Non-Preferred Pharmacy for the difference between the Carrier's payment and the Non-Preferred Provider's charge.

4. 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 Covered Person 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 Covered Persons. The Covered Person 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 Covered Person'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 Covered Person's Effective Date are the liability of the Covered Person.

   When an overpayment for benefits is made, the Carrier has the right to recover the overpayment either from the Covered Person 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 Covered Person must provide any assistance necessary, including furnishing information and signing necessary documents, for the Carrier to be reimbursed.

   This Contract does not coordinate benefits with other dental plans.

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

BLUECARD® PROGRAM

Out-of-Area Services

Overview

QCC Insurance Company ("QCC") has a variety of relationships with other Blue Cross and/or Blue Shield 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 Covered Person accesses healthcare services outside of the geographic area QCC serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When the Covered Person receives care outside of QCC's service area, the Covered Person will receive it from one of two kinds or providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. QCC explains below how QCC pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by QCC to provide the specific service or services.

A. BlueCard® Program
Under the BlueCard® Program, when the Covered Person receives Covered Services within the geographic area served by a Host Blue, QCC 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 providers.

When the Covered Person receives Covered Services outside QCC's service area and the claim is processed through the BlueCard Program, the amount the Covered Person pays for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to QCC.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Covered Person's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Covered Person'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 past pricing of claims, as noted above. However, such adjustments will not affect the price QCC has used for the Covered Person's claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

If the Covered Person receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Covered Person will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to QCC through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If QCC has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Covered Person's behalf, QCC will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

C. Nonparticipating Providers Outside QCC's Service Area

- Covered Person Liability Calculation
When Covered Services are provided outside of QCC's service area by nonparticipating providers, the amount the Covered Person pays 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, the Covered Person may be responsible for the difference between the amount that the nonparticipating provider bills and the payment QCC will make for the Covered

Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

- Exceptions
  In certain situations, QCC may use other payment methods, such as billed charges for Covered 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 QCC will pay for services provided by nonparticipating providers. In these situations, the Covered Person may be liable for the difference between the amount that the nonparticipating provider bills and the payment QCC will make for the Covered Services as set forth in this paragraph.

D. Blue Cross Blue Shield Global Core
If the Covered Person is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), the Covered Person 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 BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists the Covered Person with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when the Covered Person receives care from providers outside the BlueCard service area, the Covered Person will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If the Covered Person needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Covered Person 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 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- Inpatient Services
  In most cases, if the Covered Person contacts the service center for assistance, hospitals will not require the Covered Person to pay for covered inpatient services, except for the Covered Person's deductibles, coinsurance, etc. In such cases, the hospital will submit the Covered Person's claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a claim to receive reimbursement for Covered Services. **The Covered Person must contact QCC to obtain precertification for non-emergency inpatient services.**

- Outpatient Services
  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require the Covered Person to pay in full at the time of service. The Covered Person must submit a claim to obtain reimbursement for Covered Services.

LIMITATIONS OF CARRIER LIABILITY
The Carrier shall not be liable for injuries or damage resulting from acts or omissions of any Provider, or the acts or omissions of any other person furnishing services or supplies to the Covered Person.

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

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

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

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

PREMIUM RATES
The premium rates for this Contract 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 Contract 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.

Payment of the new premium by the Applicant shall be considered receipt of notice and acceptance of a changed premium rate.

DISCLOSURE
The Covered Person hereby expressly acknowledges their understanding that this agreement constitutes a Contract solely between the Covered Person and QCC Insurance Company (QCC), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting QCC to use the Blue Cross Service Marks in a portion of the Commonwealth of Pennsylvania and that QCC is not contracting as the agent of the Association. The Covered Person further acknowledges and agrees that they have not entered into this Contract based upon representations by any person other than QCC and that no person, entity, or organization other than QCC shall be held accountable or liable to the Covered Person for any of QCC’s obligations to the Covered Person created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of QCC other than those obligations created under other provisions of this Contract.

DISCOUNTS AND WELLNESS/REWARD INCENTIVES PROGRAMS

Discount Arrangements
Discount arrangements are not insurance. From time to time, the Carrier may offer, provide or arrange for discount arrangements or special rates from certain service providers such as, wellness and healthy living providers to Covered Persons enrolled in this Contract. 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 Covered Person for the provision of any such goods and/or services. The Carrier reserves the right to modify or discontinue such arrangements at any time. There are no benefits payable to the Covered Person nor does the Carrier compensate providers for services they may render though discount arrangements.

Wellness/Reward Incentives
In connection with a wellness or health improvement program, the Carrier may provide incentives, including but not limited to, gift certificates, prizes, or any combination thereof. The Carrier 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 Covered Person's health status.

IDENTITY PROTECTION SERVICES

From time to time, the Carrier may offer, provide or arrange for identity protection services to Covered Persons enrolled in this Contract. These services may be made available through third parties. The third party service providers are independent contractors and are solely responsible to the Covered Person for the provision of any such services. The Carrier reserves the right to modify or discontinue such services at any time.

SECTION CL - CLAIMS

NOTICE OF CLAIM
Written notice of claim must be given to the Carrier within twenty (20) days after the date when Covered Services were provided to a Covered Person. Failure to furnish within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Notice given by or on behalf of the Covered Person or beneficiary to the Carrier's address, or any authorized agent of the Carrier, with information sufficient to identify the Covered Person, shall be deemed notice to the Carrier.

FURNISHING CLAIM FORMS
The Carrier, upon receipt of a notice of claim, will furnish to the Covered Person such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements of this Contract as to filing a proof of loss upon submitting within the time fixed in this Contract for filing proofs of loss, itemized bills for Covered Services as described below. The itemized bills may be submitted to the Carrier at the address appearing on the Member's Identification Card.

PROOFS OF LOSS
Claims cannot be paid until a written proof of loss is submitted to the Carrier. Written proof of loss must be furnished to the Carrier within ninety (90) days after the date of such loss. Proof of loss must include all data necessary for the Carrier to determine benefits. Failure to furnish such proof of loss within the time specified shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS
Claim payments for benefits payable under this Contract will be processed immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all benefits for loss for which this Contract provides periodic benefits will be paid not more than thirty (30) days after receipt of proof of loss and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PHYSICAL EXAMINATIONS AND AUTOPSY
The Carrier at its own expense shall have the right and opportunity to examine the Covered Person when and so often as it may reasonably require during the pendency of claim under this Contract; and the Carrier 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 Contract shall be payable to the estate of the Covered Person, or to a Covered Person or beneficiary who is a minor or otherwise not competent to give a valid release, the Carrier may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by the Carrier to be equitably entitled thereto. Any payment made by the Carrier in good faith pursuant to this provision shall fully discharge the Carrier to the extent of such payment.

RIGHT TO RECOVER PAYMENTS IN ERROR
If the Carrier should pay for any contractually excluded services through inadvertence or error, the Carrier maintains the right to seek recovery of such payment from the Facility Provider, Professional Provider or Covered Person to whom such payment was made.

SECTION MC - MANAGED CARE

A. UTILIZATION REVIEW PROCESS

A basic condition of the Carrier's benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Necessary. To assist the Carrier in making coverage determinations for requested health care services, the Carrier uses established medical guidelines based on clinically credible evidence to determine the Medical Necessity of requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

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

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Carrier follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

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

The Carrier's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing physicians with direct access to the Carrier's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Carrier does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. **CLINICAL CRITERIA, GUIDELINES AND RESOURCES**
The following guidelines, clinical criteria and other resources are used to help make Medical Necessity coverage decisions:

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

Clinical Decision Support Criteria may be applied for Covered Services including, but are not limited to the following:
Some elective surgeries- settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery).
Inpatient hospitalizations
Inpatient Rehabilitation
Home Health
Durable Medical Equipment
Skilled Nursing Facility

Centers for Medicare and Medicaid Services (CMS) Guidelines: A set of guidelines adopted and published by CMS for coverage of services by Medicare for Medicare Covered Persons.

IBC Medical Policies: IBC, of which the Carrier is a subsidiary, maintains an internally developed set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which IBC's Medical Polices are applied include, but are not limited to:
Ambulance
Infusion
Speech Therapy
Occupational Therapy
Durable Medical Equipment
Review of potential cosmetic procedures

IBC (and QCC) Internally Developed Guidelines: A set of guidelines developed specifically by IBC (and QCC), as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting IBC Medical Policies for coverage.

C. **DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA**
In certain instances, the Carrier has delegated certain utilization review activities, including Precertification review, concurrent review, and case management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, Neonates/premature infants) or type of benefit or service (such as mental health/substance abuse or radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Carrier's approval.

Utilization Review and Criteria for Mental Health/Substance Abuse Services
Utilization Review activities for mental health/substance abuse services have been delegated by IBC (and QCC) to a behavioral health management company, which

administers the mental health and substance abuse benefits for the majority of the Carrier's Covered Persons.

D. **DISEASE MANAGEMENT AND DECISION SUPPORT PROGRAMS**

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

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

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

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

E. **PRECERTIFICATION REVIEW**

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

While the majority of services requiring Precertification review are reviewed for Medical Necessity of the requested procedure setting (e.g., Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing

provider. Precertification review is not required for Emergency services and is not performed where an agreement with the Preferred Provider does not require such review.

1. **INPATIENT PRE-ADMISSION REVIEW**

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

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

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

b. If such prior approval for a Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown below, will be deemed not to be Covered Services under this coverage. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

   If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

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

All length of stay determinations comply with state and federal length of stay regulations, including determinations of length of stay for mastectomy.

2. **EMERGENCY ADMISSION REVIEW**
   a. Preferred Admissions
      It is the responsibility of the Preferred Provider to notify the Carrier of the In-Network Emergency admission.

   b. Non-Preferred and BlueCard Provider Admissions
      1. Covered Persons are responsible for notifying the Carrier of a Non-Preferred Provider Emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Carrier.
      2. Failure to initiate Emergency admission review will result in a reduction in Covered Expense for Non-Preferred services. Such penalty, as shown below, will be the sole responsibility of, and payable by, the Covered Person.
      3. If the Covered Person elects to remain hospitalized after the Carrier and the attending Physician have determined that an Inpatient level of care is not Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

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

   All length of stay determinations comply with state and federal length of stay regulations, including determinations of length of stay for mastectomy.

   Retrospective/Post-service review:
   Retrospective/Post-service review occurs after services have been provided. This may be for a variety of reasons, including the Carrier not being notified of a Covered Person's admission until after discharge or where medical charts are unavailable at the time of concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

   Discharge Planning:
   Discharge Planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Carrier's authorization of covered post-Hospital services and identifying and referring Covered Persons to Disease Management or Case Management benefits.

   Selective Medical Review:
   In addition to the foregoing requirements, the Carrier reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("Selective Medical Review") that are otherwise not subject to review as described above. In addition, the Carrier reserves the right to waive medical review for certain Covered Services for certain Providers, if the Carrier determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services. Coverage penalties are not applied to Covered Persons where required Selective Medical Review is not obtained by the Provider.

F. **OTHER PRECERTIFICATION REQUIREMENTS**

Precertification is required by the Carrier in advance for certain services. To obtain a list of services that require Precertification, please go to www.ibx.com/preapproval or call the Customer Service telephone number that is listed on your Identification Card. When a Covered Person plans to receive any of these listed procedures, the Carrier will review the Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed on the Precertification requirements list, that are performed during an Emergency, as determined by the Carrier, do not require Precertification. However, the Carrier should be notified within two (2) business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Carrier.

1. **Preferred Care**

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

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

   For Preferred Providers in the Personal Choice Network, the Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for this financial Penalty for the Preferred Provider's failure to comply with the Precertification requirements or determination, unless a Covered Person elects to receive the treatment after review and written notification that the procedure is not covered as Medically Necessary. In which case benefits will not be provided and the Covered Person will be financially liable for non-covered charges.

2. **Non-Preferred Care**

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

   If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty, as reflected below. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

Precertification Penalty:

If the Provider is a BlueCard Provider of another Blue Plan (excluding Inpatient Admissions), or you use an out-of-network (Non-Preferred) Provider, you must obtain Precertification if required. You will be subject to a 50% reduction in benefits if Precertification is not obtained.

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

Non-Preferred (Out-of-Network) Providers. Those categories of treatment (in any setting) include:

1. Any surgical procedure that may be considered potentially cosmetic;
2. Any procedure, treatment, drug or device that represents "emerging technology", and
3. Services that might be considered Experimental/Investigative.

The Covered Person's Provider should be able to assist in determining whether a proposed treatment falls into one (1) of these three (3) categories. Also, the Carrier encourages the Covered Person's Provider to place the call for the Covered Person.

For more information, please see the ***Important Notices*** placed in the front pages of this Contract that pertain to Experimental/Investigative services, Cosmetic services, Medically Necessary services and Emerging Technology.

G. **OUT-OF-AREA CARE FOR DEPENDENT STUDENTS**

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

SECTION MR - YOUR MEMBERSHIP RIGHTS AND RESPONSIBILITIES

To obtain a list of "Rights and Responsibilities", please log on to https://www.ibx.com/quality-management#member or the Covered Person should call the Customer Service telephone number that is listed on their Identification Card to receive a printed copy.

Complaint Process

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

General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

Appeal Process

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

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

Member Appeals Department	Toll Free Phone: 1-888-671-5276 (TTY: 711)
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820	Phila. Fax: 215-988-6558

Information for the Appeal Review.

The Covered Person or authorized representative is entitled to a full and fair review. Specifically, at all appeal levels the Covered Person or authorized representative may submit additional information pertaining to the case, to the Carrier. **The Carrier takes into account all information submitted by the Covered Person, whether such information was submitted or considered during the initial Adverse Benefit Determination or prior level of review. The Carrier documents when the Covered Person fails to submit relevant information by the specified deadline.** The Covered Person or authorized representative may specify the remedy or corrective action being sought. At the Covered Person's request, the Carrier will provide access to and copies of all relevant documents, records, and other information (excluding the Carrier’s confidential, proprietary, or privileged information). The Carrier will automatically provide the Covered Person or authorized representative with any new or additional evidence considered, relied upon, or generated by the Carrier 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 Covered Person or authorized representative at no charge.

The Carrier will not terminate or reduce an-ongoing course of treatment without providing the Covered Person 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 Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Covered Persons 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.

If the appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Covered Person or authorized representative may request copies of this information at no charge. If the decision is to deny the request, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Covered Person or authorized representative may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.

Changes in Covered Persons Appeals Processes.
Please note that the Covered Persons 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 Covered Persons appeals processes, or to reflect other decisions regarding the administration of Covered Persons appeal processes for this Contract.

Types of Appeals - Following are the two types of appeals and the issues they address:

Pre-service - An appeal for benefits that, under the terms of this Contract, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available.

Post Service - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as Expedited/Urgent appeals.)

Classifications of Appeals -

Medical Necessity Appeal - An appeal by or on behalf of a Covered Person that focuses on issues of Medical Necessity and requests the Carrier to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include appeals of Adverse Benefit Determinations based on the exclusions for Experimental/Investigative or cosmetic services.

Appeal of an Administrative Denial - An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding a Carrier decision that concerns coverage terms such as contract exclusions, 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 and non-covered benefits, exhausted benefits, recissions of coverage (except for non-payment of premiums or Covered Person contributions), certain surprise medical bills received by the Covered Person from a Non-Preferred Provider and claims payment issues. Although an Appeal Of An Administrative Denial may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

Internal Standard Medical Necessity Appeal Process:

Covered Persons or their authorized representative may submit a request for a Medical Necessity Appeal either verbally or in writing to the Carrier within one hundred and eighty (180) calendar days of their receipt of the initial adverse determination.

There is one (1) level of standard Internal Medical Necessity Appeal. A Carrier Medical Director who holds an active unrestrictive license to practice medicine, who has no prior involvement with the case, and who is not a subordinate of anyone who is involved in the case makes the appeal decision. Either the Carrier Medical Director or an Independent Physician Consultant is of the same or similar specialty as the individual managing the care. The decision is made, and a notification sent to the Covered Person or authorized representative within thirty (30) calendar days of the receipt of the request for a Medical Necessity Appeal. For non-formulary exception requests, the decision is made, and notification is sent within seventy-two (72) hours of the receipt of the request.

Internal Urgent/Expedited Medical Necessity Appeal - An urgent/expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

There is one (1) level of internal urgent/expedited Medical Necessity Appeal. The review process for an urgent/expedited appeal mirrors the process described above under the section entitled "Internal Standard Medical Necessity Appeal Process".

The urgent/expedited review is completed promptly based on the Covered Person's health condition, but no later than seventy-two (72) hours after receipt of the appeal request by the Carrier. The determination is sent in writing within seventy-two (72) hours of receipt of the request to the Covered Person or authorized representative. For non-formulary urgent/expedited exception requests, the appeal is decided within twenty-four (24) hours of receipt of the expedited request and notification is sent to the Covered Person or authorized representative in writing.

For urgent care appeals, the Covered Person or authorized representative may also file an urgent/expedited external Medical Necessity review request at the same time as filing an internal urgent/expedited medical necessity appeal.

If not satisfied with the standard or expedited decision from the Carrier, the Covered Person or authorized representative has the right to initiate an external review. Please refer to the "External Review Process via an Independent Review Organization" section as described below.

Internal Standard Appeal of an Administrative Denial Process

Covered Persons or their authorized representatives may submit an Appeal Of An Administrative Denial to the Carrier verbally or in writing.

There are two (2) levels of an Appeal Of An Administrative Denial. For a Level 1 appeal request, the Covered Person or authorized representative must submit their appeal request to the Carrier within one hundred and eighty (180) calendar days of their receipt of the original adverse determination. For a Level 2 appeal, the Covered Person or authorized representative must submit their appeal request to the Carrier within sixty (60) calendar days of their receipt of the Level 1 decision letter.

Level 1 Internal Standard Appeal Of An Administrative Denial - An employee of the Carrier is the decision maker for the Level 1 Appeal Of An Administrative Denial. This individual has no previous involvement in the case and is not a subordinate of anyone previously involved. For a pre-service appeal, the decision is made, and a notification is sent to the Covered Person and or authorized representative within fifteen (15) calendar days of the Carrier's receipt of the

request. For a post-service appeal, the decision is made, and a notification is sent within thirty (30) calendar days of the Carrier's receipt of the request.

Level 2 Internal Standard Appeal Of An Administrative Denial - An employee of the Carrier is the decision maker for the Level 2 Appeal Of An Administrative Denial. This individual has no previous involvement in the case and is not a subordinate of anyone previously involved. For a pre-service appeal, the decision is made, and a notification is sent to the Covered Person or authorized representative within fifteen (15) calendar days of their receipt of the request. For a post-service appeal, the decision is made, and a notification is sent within thirty (30) calendar days of the receipt of the request by the Covered Person or authorized representative.

External Appeal of An Administrative Denial - If the Covered Person is not satisfied with the decision of the internal Level 2 Appeal Of An Administrative Denial review, the Covered Person has the right to an external appeal. The Covered Person's external Appeal Of An Administrative Denial is to be filed within **fifteen (15) calendar days of the Covered Peron's 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

The Covered Person's request for an external review of as Appeal Of An Administrative Denial should include the Covered Person's name, address, daytime telephone number, the name of the Carrier as the Covered Person's health care plan, the group number, the Covered Person's Carrier ID number and a brief description of the issue being appealed. Also include a copy of the Covered Person's original request for an internal second level standard appeal review to the Carrier and copies of any correspondence and decision letters from the Carrier.

When an external Appeal Of An Administrative Denial review request is submitted to the PID'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 the Covered Person's external review will provide the Covered Person and the Carrier 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 Carrier to the HCA3 via the HCA3 Portal**.**

External Review Process via an Independent Review Organization

External Review Process For Decisions Based On Medical Necessity Issues, Certain Surprise Medical Bills Received by a Covered Person From a Non-Preferred Provider, and Rescissions of Coverage (except for non-Payment of Premiums or Coverage Contributions).

The Covered Person or authorized representative may file a written request for an external appeal to the HCA3 within four (4) months of the Covered Person's receipt of the Carrier'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 Carrier of the assignment for each case file. The HCA3 is also responsible for keeping IRO pricing at a reasonable level. The Covered Person or authorized representative do not pay any of the cost for an external review.

For information on how to file an external appeal, please refer to the Covered Person's final adverse benefit determination letter.

A Covered Person or authorized representative may only request an external review after exhausting the Carrier's internal appeal process. The Covered Person or authorized representative shall be deemed to have exhausted the Carrier's internal appeal process in the following circumstances:

- The Covered Person or authorized representative has filed a Medical Necessity Appeal.
- Except to the extent the Covered Person or their authorized representative has requested or agreed to a delay, the Carrier has not issued a decision to the Covered Person or authorized representative within thirty (30) calendar days of when the Covered Person filed the appeal with the Carrier.
- The Carrier waives its requirement that the Covered Person or authorized representative must exhaust the internal claim and appeal process prior to filing a request for an external review or expedited external review.
- The Carrier 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.

Preliminary Review of an External Review Request

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

- The individual is or was a Covered Person 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 Covered Person's health insurance policy, except for determinations by the Carrier that a health care service is not covered because it does not meet the Carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
- The Covered Person has exhausted the Carrier's internal Medical Necessity Appeal process.
- The Covered Person 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 Carrier's preliminary review will also include a determination of whether:

- The health care service is covered under the Covered Person's health insurance policy, except for the Carrier'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 Covered Person's health insurance policy.
- The Covered Person'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 Covered Person.
    - Standard health care services are not medically appropriate for the Covered Person.
- 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 Covered Person, 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 Covered Person who is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination, are likely to be more beneficial to the Covered Person 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 Covered Person's condition.

Within one (1) business day of completion of the preliminary review, the Carrier notifies the HCA3, the Covered Person or authorized representative in writing whether the request is complete and eligible for external review.

The HCA3 sends written notification to the Covered Person or 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 Covered Person or 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 Covered Person or authorized representative, the IRO sends a copy of the information to the Carrier.

Within five (5) business days of receipt of the name of the assigned IRO from the HCA3, the Carrier 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 Carrier 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 Carrier's decision. The IRO notifies the Covered Person or authorized representative, the HCA3, and the Carrier of the action they have taken within one (1) business day of making their decision.

Reconsideration by the Carrier

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

An external review may be terminated without an IRO determination if the Carrier 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 Carrier will notify the HCA3, IRO, and the Covered Person or 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 Covered Person or authorized representative within forty-five (45) calendar days of receipt of the external review request. For an external review of experimental or investigational treatment, the assigned IRO makes a decision and sends notification to the Covered Person or authorized representative within twenty (20) calendar days of receipt of the external review of experimental or 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 Carrier will approve the request that was the subject of the external review within twenty-four (24) hours of receipt of the IRO decision.

Expedited External Review

The Covered Person or 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 Covered Person or authorized representative may request an expedited external review in the following circumstances:

- The Covered Person has an Urgent Care condition for which the time for a standard external review decision would seriously jeopardize the life, or health of the Covered Person 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 Covered Person receives emergency care but has not been discharged from a facility.

For information on how to file an expedited external appeal, please refer to the Covered Person's final adverse benefit determination letter.

A Covered Person or 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 Covered Person 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 Covered Person or would jeopardize the Covered Person'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 Covered Person'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 Carrier within twenty-four (24) hours.

- Within twenty-four (24) hours of receipt of the request from the HCA3, the Carrier determines if the request meets the requirements for an external review and notifies the HCA3 and Covered Person or authorized representative of the Carrier's eligibility determination.
    - The Covered Person or authorized representative may appeal the Carrer initial determination that the external review request is ineligible for review to the HCA3.
    - Despite the Carrier's initial determination, the HCA3 may determine, based upon the terms of the Covered Person's health insurance policy, that a request is eligible for external review. This determination will be binding on the Carrier and the Covered Person 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 Carrier'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 Carrier 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 Covered Person or authorized representative, the HCA3, and the Carrier. For non-formulary exception requests, the IRO makes their decision within twenty-four (24) hours of the request and notifies the Covered Person or authorized representative, the HCA3, and the Carrier.

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

Binding Decision for External Reviews

An IRO decision is binding on the Carrier except to the extent the Carrier has other remedies available under applicable state law. An IRO decision is binding on the Covered Person or authorized representative, except to the extent the Covered Person or authorized representative has other remedies available under applicable Federal and state laws.

Neither the Covered Person 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 Covered Person has already received a decision for the same Adverse Benefit Determination or final Adverse Benefit Determination.

If the Covered Person's health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the Covered Person's appeal the Covered Person may have the right to bring civil action under Section 502(a) of the Act. For questions about the Covered Person's rights, this notice, or for assistance, the Covered Person can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) (TTY: 711). Additionally, a consumer assistance program may be able to assist the Covered Person at:

Pennsylvania Insurance Department
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388 (TTY: 711)
www.insurance.pa.gov

If the Carrier fails to "strictly adhere" to the internal appeals process, the Covered Person may initiate an external review or file appropriate legal action under state law or ERISA unless:

- Violation was *de minimis* (minimal).
- Did not cause (or likely to cause) prejudice or harm to the claimant.
- Was for good cause or due to matters beyond the control of the insurer/plan.
- In the context of a good faith exchange of information with the claimant.
- Not part of a pattern or practice of violations.

Personal Choice® Claims Reimbursement Example:

You pay:
20% in-network coinsurance, up to a $8,750 individual/ $17,500 family out-of-pocket maximum
50% out-of-network coinsurance, up to a $12,000 individual/ $24,000 family out-of-pocket maximum

Outpatient Hospital Claim Example for Colonoscopy (when provided by Facility Providers that are not Hospital Based)

	IN-NETWORK	OUT-OF-NETWORK
	Personal Choice Network or BlueCard® Facility	Non-Preferred Facility Provider*
Hospital's Billed Charge	$4,965.00	$4,965.00
Contract Covered Expense	$2,534.92 For Personal Choice Network hospital services provided by a hospital in the Personal Choice local service area, the Contract Covered Expense is the amount payable to the hospital under the contractual arrangement with IBC. For BlueCard hospital services, the Contract Covered Expense is, in most cases, the price or fee that has been determined in advance under the hospital's agreement with their local Blue Cross® Blue Shield® Plan.	$769.11 Medicare Allowable Payment There is no discount for services received in a hospital that does not participate in the Personal Choice Network or BlueCard Program. For outpatient covered services provided by a Non-Preferred Facility Provider, the Contract Covered Expense is lesser of the Medicare Allowable Payment for Facilities or the provider's charges. For covered services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of IBC's applicable proprietary fee schedule or the provider's charges. For covered services that are not recognized or reimbursed by the Medicare traditional program or IBC's applicable proprietary fee schedule, the amount is determined by reimbursing the lesser of IBC's applicable proprietary fee schedule or the provider's charges.

		For covered services not recognized or reimbursed by the Medicare traditional program or IBC's applicable proprietary fee schedule, the amount is determined by reimbursing fifty percent (50%) of the provider's charges for covered services.
What You are Responsible to Pay	$0 (A colonoscopy is considered an adult preventive service and not subject to a deductible or coinsurance when provided by Facility Providers that are not Hospital Based)	$384.55 + $4,195.89 = $4,580.44 (50% coinsurance of Contract Covered Expense, up to $12,000 individual out-of-pocket maximum + difference between Contract Covered Expense and Hospital's Billed Charge)

* Non-Preferred Providers may balance bill a Personal Choice member for differences between the Contract Covered Expense, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. The balance bill amount will not count toward the out-of-pocket maximum.

QCC INSURANCE COMPANY

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 Carrier. 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 Carrier.

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)

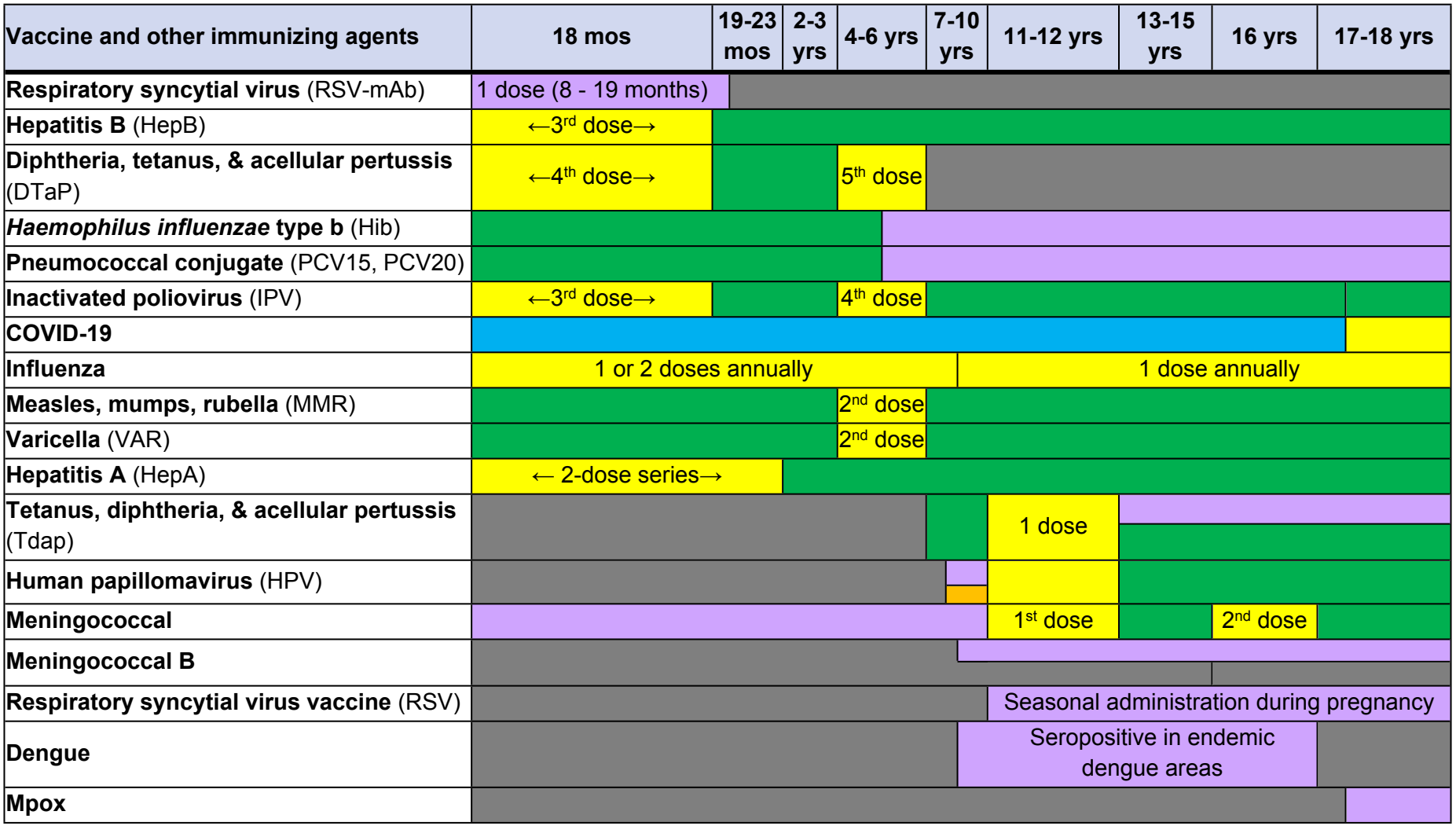
Birth to 15 Months

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

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 Carrier.

PREV/SCH-II Rev. 1.27

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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