KEYSTONE HEALTH PLAN EAST, INC.
(hereafter called "Keystone" or “Health Benefits Plan” or “Claims Administrator”)

RIDER

This Rider modifies your Health Benefits Plan’s or Claims Administrator’s, as applicable, benefit description material with updates to the plan’s Covered Services. Unless noted otherwise, the effective date of these changes is the later of:

(a) January 1, 2017;
(b) the Contract Date;
(c) the Member’s Effective Date of Coverage; or
(d) the Group Master Contract’s anniversary date coinciding with or the next following January 1, 2017.

A. The following changes are made with regard to BlueCard benefits:

1. The Out-of-Area Services provision under the Program Design Features sub-section of the General Information section is replaced in its entirety with the following:

OUT-OF-AREA SERVICES

Overview

Keystone Health Plan East, Inc. ("Keystone") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever the Member obtains healthcare services outside of Keystone’s Service Area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When the Member receives care outside of Keystone’s Service Area, they will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield in that geographic area ("Host Blue"). Some providers (“non-participating providers”) don’t contract with the Host Blue. Keystone explains below how we pay both kinds of providers.

Keystone covers only limited healthcare services received outside of our Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care, Urgent Care and Follow-up Care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the Member's Primary Care Physician ("PCP").

BlueCard® Program
Under the BlueCard® Program, when a Member obtains Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Keystone will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables the Member to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to the Member, so there are no claim forms for the Member to fill out. The Member will be responsible for the Copayment amount, as stated in the ***Schedule of Cost Sharing & Limitations***.

Emergency Care Services: If the Member experiences a Medical Emergency while traveling outside Keystone's Service Area, go to the nearest Emergency or Urgent Care facility.

When the Member receives Out-of-Area Covered Healthcare Services outside Keystone's Service Area and the claim is processed through the BlueCard Program, the amount the Member pays for the Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the Member's Covered Services; or
- The negotiated price that the Host Blue makes available to Keystone.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over-or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price Keystone has used for the Member's claim because they will not be applied after a claim has already been paid.

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Keystone will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Non-Participating Healthcare Providers Outside Keystone's Service Area

Your Liability Calculation

When Out-of-Area Covered Healthcare Services are provided outside of Keystone's Service Area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Keystone will make for the Out-of-Area Covered Healthcare Services as set forth in the Group Contract. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

Exceptions

In certain situations, Keystone may use other payment methods, such as billed charges for Out-of-Area Covered Healthcare Services, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment to determine the amount Keystone will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment Keystone will make for the Out-of-Area Covered Healthcare Services as set forth in the Group Contract.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you may be able to take advantage of BCBS Global Core when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although BCBS Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you should call the BCBS Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if you contact the BCBS Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact Keystone to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

B. The following changes are made with regard to Blood Pressure Cuffs:

1. The provision pertaining to Blood Pressure Cuffs under the **Exclusions-What is Not Covered** section is replaced with the following:

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

C. The following changes are made with regard to Chemotherapy benefits:

1. The description of Chemotherapy under the Therapy Services provision of the Outpatient Services sub-section, of the **Description of Covered Services** section is replaced in its entirety with the following:

   Chemotherapy
   The treatment of malignant disease by chemical or biological antineoplastic agents used to kill or slow the growth of cancerous cells. Such agents are eligible for coverage when they are injected or infused into the body by a professional provider. The cost of these drugs is covered, provided the drugs are approved by the U.S. Food and Drug Administration (FDA) as antineoplastic agents and administered as described in this paragraph.

   Note: If this Program does not provide coverage for prescription drugs, oral antineoplastic agents are covered as provided under the benefits described above.

2. The definition of Chemotherapy under Therapy Services of the **Important Definitions** section is replaced in its entirety with the following:

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

D. The following changes are made with regard to coverage of Specialty Drugs:

1. The description of the Specialty Drugs benefit under the Prescription Drugs provision of the Outpatient Covered Services sub-section of the **Description of Covered Services** section is replaced with the following

   Specialty Drugs -The Health Benefit Plan, or Claims Administrator, as applicable, will only provide benefits for covered Specialty Drugs through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program for the appropriate cost sharing indicated in the "Prescription Drugs" subsection of the Schedule of Covered Services section. Benefits are available for up to a 30-day supply. No benefits shall be provided

for Prescription Drugs obtained from a Specialty Pharmacy Program other than the PBM's Specialty Pharmacy Program. The responsibility to initiate the Specialty Pharmacy process is the Members'.

E. The following changes are made with regard to Medical Foods benefits:

1. The description of the Medical Foods and Nutritional Formulas benefit under the Outpatient Services sub-section of the **Description of Covered Services** section is replaced in its entirety with the following:

Medical Foods and Nutritional Formulas

- The Health Benefit Plan, or Claims Administrator, as applicable, will provide coverage 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.

- The Health Benefit Plan, or Claims Administrator, as applicable, will provide coverage for Nutritional Formulas when the Nutritional Formula is taken orally or through a tube by an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

- The Health Benefit Plan, or Claims Administrator, as applicable, will provide coverage 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 Program.

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.

2. The Medical Foods and Nutritional Formulas provision under the **Exclusions-What is Not Covered** section is replaced in its entirety with the following:

Medical Foods And Nutritional Formulas

- For appetite suppressants; and
- For oral non-elemental nutritional supplements (For example, Boost, Ensure, PediaSure), casein hydrolyzed formulas (For example, Nutramigen, Alimentun, Pregestimil), or other nutritional products including, but not limited to, banked breast milk, basic milk, milk-based, soy-based products. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the ***Description of Covered Services***.
- For elemental semi-solid foods (e.g. Neocate Nutra)
- For products that replace fluids and electrolytes (e.g., Electrolyte Gastro, Pedialyte)

- For additives (e.g., Duocal, fiber, or vitamins) and food thickeners (e.g., Thick-It, Resource ThickenUp)
- For supplies associated with the oral administration of formula (e.g., bottles, nipples)

3. The description of the Medical Foods under the **Important Definitions** section is replaced with the following:

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

F. The following changes are made to the Prescription Drug 'Select Drug Program,' if applicable to your benefit plan, with regard to Formulary Drugs:

1. The **Schedule of Covered Services** section is revised as follows:

   a. The term Brand Formulary Drug is replaced throughout the section with Preferred Brand Drug.

   b. The term Generic Formulary Drug is replaced throughout the section with Generic Drug.

2. The **Important Definitions** section is revised as follows:

   a. The definition of Preferred Brand Drug is added:

      Preferred Brand Drug
      These drugs have been selected for their reported medical effectiveness, safety, and value. These drugs generally do not have generic equivalents.

   b. The definition of Non-Preferred Drug is added:

      Non-Preferred Drug
      These drugs generally have one or more generic alternatives or preferred brand options within the same drug class

   c. The definition of Non-Formulary Drug currently included in the section is deleted.

3. The term Non-Formulary Drug is replaced throughout the entire Benefit Booklet with the term Non-Preferred Drug.

G. The following changes are made with regard to treatment of Obesity:

1. The Obesity provision under the **Exclusions-What is Not Covered** section is replaced in its entirety with the following:

   Obesity
   Treatment of obesity, including, but not limited: (a) weight management programs; (b) dietary aids, supplements, injections and medications; (c) weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician; (d) group nutrition counseling.

This exclusion does not apply to:

- Surgical procedures specifically intended to result in weight loss (including bariatric surgery) when the Health Benefit Plan, or Claims Administrator, as applicable:
  - Determines the Surgery is Medically Necessary; and
  - The Surgery is limited to one surgical procedure per lifetime regardless (or even) if:
    - A new or different diagnosis is the indication for the Surgery;
    - A new or different type of Surgery is intended or performed;
    - A revision, repeat, or reversal of any previous weight loss Surgery is intended or performed.

  The exclusion of coverage for a repeat, reversal or revision of a previous Surgery does not apply when the intended procedure is performed to treat technical failure or complication of a prior surgical procedure which if left untreated, would result in endangering the health of the Member. Failure to maintain weight loss or any condition resulting from or associated with obesity does not constitute technical failure.

- Nutrition counseling visits/sessions as described in the "Nutrition Counseling for Weight Management" provision in this Benefit Booklet.

H. The following changes are made with regard to treatment of Routine Foot Care:

1. The Foot Care provision under the **Exclusions-What is Not Covered** section is replaced in its entirety with the following:

   Routine Foot Care
   As defined in the carrier's medical policy unless associated with Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes.

I. The following changes are made with regard to coverage of Transplants:

1. The description of Transplant Services under the Inpatient/Outpatient Services sub-section of the **Description of Covered Services** section is replaced in its entirety with the following:

   Transplant Services
   When the Member is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Covered Services. Covered Services for Inpatient and Outpatient Care related to the transplant include procedures which are generally accepted as not Experimental/Investigational Services by medical organizations of national reputation. These organizations are recognized by the Health Benefit Plan, or Claims Administrator, as applicable, as having special expertise in the area of medical practice involving transplant procedures. Benefits are also provided for those services which are directly and specifically related to the Member's covered transplant. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of blood provided to the Member.

The determination of Medical Necessity for transplants will take into account the proposed procedure's suitability for the potential recipient and the availability of an appropriate facility for performing the procedure.

Eligibility for Covered Services related to human organ, bone and tissue transplant are as follows.

If a human organ or tissue transplant is provided by a donor to a human transplant recipient:

- When both the recipient and the donor are Members, the payment of their respective medical expenses shall be covered by their respective benefit programs.
- When only the recipient is a Member, and the donor has no available coverage or source for funding, benefits provided to the donor will be charged against the recipient's coverage under the Benefit Booklet. However, donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program.
- When only the recipient is a Member and the donor has available coverage or a source for funding, the donor must use such coverage or source for funding as no benefits are provided to the donor under the Benefit Booklet.
- When only the donor is a Member, the donor is entitled to the benefits of the Benefit Booklet for all related donor expenses, subject to following additional limitations:

  - The benefits are limited to only those benefits not provided or available to the donor from any other source of funding or coverage in accordance with the terms of the Benefit Booklet; and
  - No benefits will be provided to the non-Member transplant recipient.

- If any organ or tissue is sold rather than donated to the Member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered. Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program. Covered Services of a donor include:

  - Removal of the organ;
  - Preparatory pathologic and medical examinations; and
  - Post-surgical care.

J. The following changes are made with regard to the treatment of Sexual Dysfunction:

1. The Sexual Dysfunction provision under the **Exclusions-What is Not Covered** section is replaced in its entirety with the following:

   Sexual Dysfunction
   Sex therapy or other forms of counseling for treatment of sexual dysfunction.

K. The following changes are made for compliance with the Affordable Care Act (ACA) with regard to Non-Discrimination Rights:

   1. The Transsexual Surgery provision under the **Exclusions-What is Not Covered** section is deleted.

The Benefit Booklet is changed only as stated in this Rider. All provisions of the Benefit Booklet not changed by this Rider still apply.

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