Protecting your privacy and health information

At Independence Blue Cross (Independence), protecting your privacy is very important. That’s why we have implemented measures to keep our members’ protected health information (PHI) confidential. PHI is individually identifiable health information about you; it may be in oral, written, or electronic form.

We may obtain or create your PHI as part of our business: providing you with health care benefits. Our policies and business procedures cover the collection, use, and disclosure of PHI. We continually review these policies and procedures to make sure that your information is protected and at the same time available as needed to provide your health benefits. For example, procedures are in place to help us verify the identity of someone requesting PHI and to place limits on which staff members can access your PHI. We share only the minimum amount of information necessary when PHI must be disclosed. We also protect any PHI that is electronically transmitted outside our organization by using only secure networks and encryption technology.

Examples of business situations in which we are permitted to use or disclose your PHI include:

• Paying your claims
• Coordinating the delivery of health care services
• Monitoring the performance of network providers regarding health care outcomes

In certain other circumstances, we may also share your PHI with health care oversight and government agencies for legally authorized activities, such as audits and investigations, or when we are required to do so by law. We may also share certain information with the sponsor of your group health plan for administration purposes.

Releasing protected health information

We do not use or share your PHI without your permission unless permitted by law. You can authorize us to share your PHI with someone you choose. You may wish to have certain individuals view or receive part or all of your PHI, if necessary. For instance, you may have an adult son or daughter to whom you turn to for assistance coordinating your medical care or paying your medical expenses. We can disclose your PHI to any person or organization you choose, provided you complete an Authorization to Release Information form and return it to us for our records.

To do so, print a copy of our Authorization to Release Information form from our website at ibxpress.com. Log on and select the Resource Center tab, then the Authorizations button from the menu on the left. Or request a copy by calling Customer Service at 1-800-ASK-BLUE (1-800-275-2583, TTY: 711).

The laws that protect your privacy also give you certain rights regarding your PHI. For example, you may request a copy of your PHI on file at Independence by contacting Customer Service. Please remember that we typically do not have copies of your medical records. You should contact your health care provider for copies of your medical records.

To learn more about your privacy rights

Please review our Notice of Privacy Practices for more detailed information about your privacy rights and how we may use and share your PHI. You may view or print a copy by logging in to ibxpress.com and selecting Privacy Policy at the bottom of the page. You also can call Customer Service to request a copy.
Member rights and responsibilities

Independence Blue Cross (Independence) would like to take this opportunity to thank you for being an Independence health plan member. We are dedicated to keeping our members healthy and informed. We not only respect your rights, but we also encourage you to exercise your responsibilities. The following are your rights and responsibilities as an Independence member.

**Member rights**

- You have the right to be provided with information concerning the managed care organization and its policies and procedures regarding products, services and benefits, participating providers, grievance/appeal procedures, and other information about the organization, the care provided, and member rights and responsibilities. Written information provided to you will be readable and easily understood.

- You have the right to be treated with courtesy, consideration, respect, and recognition of your dignity and your right to privacy.

- You have the right to participate with providers in decision-making regarding your health care. This includes candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefits coverage.

- You have the right to file or voice complaints or appeals with or about the managed care organization, or care provided, and to receive a timely response.

- Upon exhaustion of the internal member appeal process, you may have the right to file for external review.
  
  - For national PPO members: For a medical necessity appeal, you have the right to file an external appeal with an independent review organization. External appeal instructions are provided in the decision letter for the final level of internal appeal review. There is no external appeal review process for administrative appeals. Appeal rights may differ for members of self-insured plans.
  
  - For Keystone Health Plan East HMO/POS and Personal Choice® PPO members: You may have the right to file for external review by state regulatory authorities or an independent review organization. Your external appeal rights vary and will depend on whether you are enrolled in an HMO, POS, or PPO plan; your health plan is fully insured or self-insured; and your appeal is about a medical necessity issue or an administrative issue. For more information, see the appeal instructions in the decision letter for your final level of internal member appeal review.

- You have the right to choose providers within the limits of the covered benefits and plan network, including the right to refuse the care of specific providers.

- You have the right to the confidential treatment of medical information. You have the right to have access to your medical records in accordance with applicable federal and state laws.

- You have the right to reasonable access to medical services, including availability of care 24 hours a day, 7 days a week, for urgent or emergency conditions.

- You have the right to receive health care services without discrimination based on race, skin color, ethnicity, age, mental or physical disability, religion, gender, genetic information, national origin, or source of payment.

- You have the right to formulate advance directives. The plan will provide information to members and providers concerning advance directives and will support members through its medical record-keeping policies.

- You have the right to make recommendations regarding your health plan’s policy on member rights and responsibilities. To make any recommendations, please call Customer Service at **1-800-ASK-BLUE** (TTY: 711).
Member responsibilities

- You have the responsibility to communicate, to the extent possible, information that the managed care organization and participating providers in our network require in order to care for you.

- You have the responsibility to ask questions to make sure that you understand the explanations given to you regarding your health problems and to follow the plans and instructions for the care and treatment goals that you agreed on with your providers. This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.

- You have the responsibility to review all benefits and membership materials carefully and to follow the regulations pertaining to your health plan.

- You have the responsibility to treat your health care providers with the same respect and courtesy you expect for yourself.

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

Note: Magellan Behavioral Health, Inc., an independent company, provides similar rights and responsibilities. Magellan manages mental health and substance abuse benefits for most members.
Notice of Privacy Practices

Independence Blue Cross (Independence) is committed to protecting the privacy of our members’ personal health information. Part of that commitment is complying with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires us to take additional measures to protect personal information and to inform our members about those measures.

The Notice of Privacy Practices describes how Independence may use and disclose a member’s personal health information and how a member of an Independence health plan can get access to this information. For details on our practices, available privacy forms, and HIPAA requirements, please visit ibx.com/privacy. You can also call to request a copy of the Notice of Privacy Practices by contacting Customer Service at the number on the back of your ID card.
Maintaining your privacy

Gramm-Leach-Bliley Notice of Privacy Practices

At Independence Blue Cross LLC (Independence),* we value you as a member, and the protection of your personal information is very important to us. To administer effectively the array of health plans offered to our members, Independence may collect and share “nonpublic personal information” about you in accordance with applicable laws and regulations. This notice is provided as required by the Gramm-Leach-Bliley Act, a federal law, and applicable state regulations. This notice informs you how we collect, share, and protect your personal information.

Nonpublic personal information

Independence collects nonpublic personal information about you when you apply for health care coverage with Independence or when Independence administers your benefits. For example, Independence may collect personal information such as your name, address, phone number, cell phone number, Social Security number, and account information, which may not otherwise be publicly available. Independence receives this information from:

- You, your employer, or benefits plan sponsor on applications and other forms
- Your transactions with Independence, our affiliates, or others
- Consumer reporting agencies
- Electronic sources when you access our website, including data that is obtained with an information-collection device known as a “cookie”

Nonpublic personal information

Independence does not disclose nonpublic personal information about our customers or former customers to anyone, except as otherwise permitted by law. For example, Independence may disclose nonpublic personal information to affiliates and non-affiliated third parties to perform services on our behalf or as necessary for everyday business purposes such as to process your transactions, maintain your account, respond to court orders, or report to credit bureaus.

Our security procedures

Independence restricts access to nonpublic personal information about you to individuals or entities involved in providing services to you. Independence maintains safeguards to protect nonpublic personal information from unauthorized access and use.

Please call 1-800-ASK-BLUE (1-800-275-2583, TTY: 711) or go to ibx.com/privacy if you have any questions about this notice.

* For purposes of this notice, “Independence” refers to the following companies: Independence Blue Cross, LLC; Keystone Health Plan East, Inc.; and QCC Insurance Company.
2016 tax reporting

Under the Affordable Care Act, most U.S. citizens and legal residents must have health care coverage. This is know as the “Individual Mandate.”

To prove that you and any of your dependents had the required health care coverage in 2015, you will need to include IRS Form 1095 with your tax returns.

You will receive a 1095 if you purchased insurance for yourself and your family or if you are enrolled in a group health plan provided by your employer or union.

The forms will mail by the end of January 2016. For more information about how new IRS reporting requirements under the ACA affect you, please consult with your tax advisor.
Our utilization review policy

It is the policy of Independence Blue Cross and its affiliates ("Plans") that all utilization review decisions are based on the benefits available under the member’s coverage and the medical necessity of health care services and supplies in accordance with the Plans’ definition of medical necessity.

Only physicians can make denials of coverage of health care services and supplies based on lack of medical necessity. The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for the Plans are not compensated or given incentives based on their coverage review decisions. Medical directors and nurses are salaried, and contracted external physicians and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination.

The Plans do not provide financial incentives for issuing denials of coverage or utilization review decisions that result in underutilization.

If you have questions about the utilization decision process or a determination you have received, you can call Customer Service at the telephone number on the back of your insurance card. Customer Service will provide assistance with understanding the process or transfer you to the Utilization Management Department to discuss your concerns.
Finding a network provider

Our Find-a-Doctor tool makes it easy to search our broad network for a doctor or hospital. Log on to find easy-to-follow, up-to-date, detailed listings of doctors and hospitals — information you can use to make informed decisions about your health care.

Find a Doctor is available through ibx.com and ibxpress.com. With Find a Doctor, you can:

• **Search for a participating doctor or hospital.** *You can search by name, location, specialty, or medical procedure to find the physicians, hospital, or treatment center. You can also access valuable information, such as the provider’s gender, hospital admitting privileges, and languages spoken at the practice. You can also review and compare the qualifications and experience of network physicians. Or research and compare hospitals based on procedure, diagnosis, and location, as well as hospital quality and safety information. You can also customize the way the results are displayed according to which measures (number of patients, complication and mortality rates, length of stay, and cost) are most important to you.*

• **Read and post reviews.** Learn from the experience of others. If you’re registered on ibxpress.com, you can also post your own ratings.

• **Compare the cost of basic procedures.** Find a Doctor gives you a range for nearly 150 health care procedures.

**Go online**

Go to ibx.com or log on to ibxpress.com to use these valuable resources. If you do not have Internet access, call Customer Service at 1-800-ASK-BLUE to obtain a copy of the Provider Directory for your coverage (HMO, POS, or PPO).

*The provider tool includes information on all physicians, hospitals, and ancillary providers who participate in our managed care plans. Managed care products include Keystone HMO/POS, Personal Choice® PPO, National BlueCard® PPO, and our Medicare Advantage plans.*
How to plan for your doctor visit

You can make your next trip to the doctor go as quickly and smoothly as possible with these helpful tips:

- **Check to make sure you have your current plan ID card with you before leaving for your appointment.**

- **Ask whether you can pay your copayment when you arrive for your appointment.**
  Your office visit copayment amount is located on the front of your ID card. Using some of your waiting room time for the business part of your visit lets you move on to the rest of your day as soon as you are finished seeing the doctor.

- **Keep your medical records current.** If your address, phone number, or ID number has changed since your last visit, be sure to tell the doctor’s office staff.

- **Take along a list of all the prescription medications, over-the-counter medications, and herbal remedies that you are taking to identify any possible drug interactions.** Also take the names of doctors currently treating you and details about any recent hospitalizations. This will help the doctor know how to treat you and coordinate your care.

**For Keystone Health Plan East members**

If you have an appointment with a specialist, your primary care physician should have submitted a referral through the electronic submission process. If you want a hard copy of the referral, you can view and print copies of any referrals that were issued to you by logging on to ibxpress.com. Select **View Open Referrals** located under the **Benefits** tab.

**Use your Wellness Profile**

An easy way to share important health information with your doctor is to bring a printed copy of your Wellness Profile to appointments. To get your copy, log on to ibxpress.com and select **Wellness Profile**, at the center of the page View and print a physician summary report by clicking on the link at the bottom of the page.
Independence standards for doctor appointments, wait times, hours and access

When you need medical care, seeing a doctor should be fast and easy. Independence Blue Cross (Independence) has put these standards in place to get you the service you need, when you need it.

Appointment availability

In conjunction with the doctors in our network, we have set standards for the scheduling of patients’ appointments:

- In a medically urgent situation, you should receive an appointment within 24 hours.*
- For a routine visit, you should be able to schedule an appointment with your doctor within two weeks.
- For a routine physical, you should be able to schedule an appointment with your doctor within four weeks.

In an emergency, you should get medical help as soon as possible.†

Wait times

No one likes to be kept waiting. We have asked our network doctors to set a goal of seeing you within 30 minutes of your scheduled appointment time.

Of course, unforeseen events may prevent your doctor from achieving that goal all the time. You may experience an occasional delay. However, the objective is to ensure that you consistently have access to medical care within an acceptable waiting period.

Access after normal business hours

Urgent or emergency medical advice should be available 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 a covering physician. A physician should call you within 30 minutes.

Your access to behavioral health care‡

To access behavioral health services (including mental health and substance abuse services), members may call the telephone number on their ID card. We have established the following standards for scheduling behavioral health services:

- In the case of a life-threatening emergency, you should be seen within one hour of the crisis call or be directed to your nearest emergency department.
- In a situation that is not life-threatening, you should be seen within six hours of the crisis call.
- For an urgent situation, you should be offered an appointment within 48 hours.
- For a routine visit, you should be offered an appointment within 10 business days.

For Keystone HMO and POS members

- **Primary care.** Keystone Health Plan East (KHPE) members choose a primary care physician (PCP) on enrollment. In order to find out whether your PCP is a participating provider, or to find a participating provider, log on to ibx.com/find_a_provider. To change PCPs, log on to ibxpress.com and choose My Care tab. You can also call the Customer Service number on the back of your ID card.

- **Specialty care.** To have specialist visits covered, KHPE members must request a referral from their PCP. This helps your PCP coordinate your treatment and any medication and helps avoid unnecessary or duplicate tests. Your PCP will submit an electronic referral to the specialist indicating the services authorized. Your referral is valid for 90 days from the issue date as long as you are a KHPE member.
Make sure the specialist or facility has received the referral before the services are performed. Only services authorized on the referral are eligible for coverage. If the referred specialist recommends additional medically necessary care after the initial 90-day window has expired, another electronic referral from your PCP will be required. If you would like a copy of the referral form, you can view and print copies of any referrals that have been issued to you by logging on to ibxpress.com.

- Obstetrical/gynecological care. Members may seek care from a KHPE-participating obstetrician or gynecologist without a referral for all gynecological care.

**For Keystone Direct POS members**

Keystone Direct POS members do not need referrals for most specialty care services.

Note: Please refer to your benefits description materials for the terms, limitations, and exclusions of your health care coverage.

* Urgent care is medical attention you need right away for an unanticipated illness or injury.
† An emergency is defined as a medical condition manifesting itself in acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or place one’s health in serious jeopardy. If you are experiencing symptoms that might reasonably indicate such a condition (such as severe chest pain or a broken arm), you may need emergency care and should go immediately to the emergency department of the closest hospital. Health concerns of a pregnant woman may also extend to her unborn child. If you believe your situation is an emergency, you should call 911. Please note that “emergency services” are covered benefits in accordance with your contract. Your benefits description materials contain a complete and more detailed definition of “emergency” with which you should become familiar. It is this definition that determines whether your condition, injury, or illness will be covered as an emergency service.
‡ Magellan Behavioral Health, Inc., an independent company, manages mental health and substance abuse benefits for most members.
Making a primary care physician appointment
(HMO only)

To schedule an appointment with your primary care physician (PCP), call the PCP’s office and identify yourself as a Keystone Health Plan East (KHPE) member who has selected the office as your PCP. Whenever possible, make the call in advance of the day you want the appointment. If you are injured or have an urgent medical problem that cannot wait, be sure to contact your PCP. You will be advised about what to do.

When you arrive for your appointment, please show your current KHPE ID card, which you should carry with you at all times. If, for some reason, you cannot keep your appointment, be sure to call the office to cancel it so that your scheduled time can be used by someone else.

Also, please remember that your PCP is prepared to see only the member for whom an appointment is made. Please do not ask your doctor to see other family members as part of your appointment.
Hospital care procedures for HMO members

If you need outpatient services, surgery, or hospitalization, your primary care physician (PCP) will provide any referrals that your plan — Keystone Health Plan East (KHPE) — might require.

If your PCP refers you to a specialist who then determines that you need outpatient services, surgery, or hospitalization, the specialist will coordinate the prior authorization (approval in advance) with KHPE. Prior authorization is not needed if you require emergency admission.

Once you are discharged from the hospital, we highly recommend that you follow up with your PCP to review your medications, especially if there has been a change during a hospital admission.

If you have questions, call Customer Service at the number on the back of your member ID card.
Differences between emergency care and urgent care

There is a difference between emergency care and urgent care. Understanding this important difference helps you know when to go to a hospital emergency room and when to seek care from your physician or other health care provider, such as an urgent care center or retail clinic.

If you need to go to a hospital emergency room, remember that emergency rooms must prioritize patients’ needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you may wait a long time before receiving care.

What is an emergency?

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.

A medical emergency could include severe chest pain. If you are experiencing symptoms that may indicate an emergency condition, you should go immediately to the emergency room of the closest hospital.

If you believe your situation is life-threatening, you should call 911 or go immediately to the emergency room of the nearest hospital. With an emergency condition, you can directly access medical care that does not require prior approval.

If you had emergency care, be sure to notify your primary care physician (PCP) or personal physician, even if follow-up treatment is not needed.

What is urgent care?

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

You may visit an urgent care center, which offers a convenient, safe, and affordable treatment alternative to emergency room care, when you can’t get an appointment with your own doctor. Many urgent conditions require follow-up care that is best provided or coordinated by your PCP or personal physician.

What if my PCP is not available?

When you are unable to get an appointment with your PCP, and you have an urgent care benefit, urgent care centers and retail health clinics are an easy, safe, and less costly option to the emergency room. Urgent care centers have board-certified doctors who can give you care for an illness or injury that needs medical attention right away but is not life-threatening.

Retail health clinics have certified nurse practitioners who can treat simple illnesses and injuries. If you are seen at an urgent care facility or retail health clinic, notify your PCP. You may also need to schedule a follow-up appointment with your PCP, not the urgent care center or retail health clinic where you were treated.

When in doubt, call your physician

If you are unsure whether your condition is an emergency or an urgent condition, call your physician. He or she knows you and your medical history and can best assess your condition. Based on your symptoms, your physician may send you to a hospital emergency room. Your physician may also arrange to see you for an evaluation and treatment in the office or suggest another option.
Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

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Understanding advance directives

Do you have a living will or advance directive — a document that spells out how you want to be cared for in the event that you cannot articulate your wishes?

Many of us do not think about such issues until we are admitted to a hospital. That is when, in accordance with federal law, we are asked if we have signed any such documents.

Of course, that is probably the worst time to make such decisions, particularly in an emergency, when you may not be able to think clearly. It may be best to discuss these matters with your family, your physician, and anyone else involved in your care before a medical emergency occurs. If you have a lawyer, he or she may be able to help you write up your wishes in a formal document.

Advance directives can take various forms

- **Living will.** This document expresses your wishes should you become terminally ill or be in a persistent vegetative state. You state whether you would want to be kept alive through such measures as tube feeding, artificial respiration, or heart resuscitation. For a living will to be valid, it must be in writing and signed, dated, and witnessed by two adults.

- **Health care agent.** This is someone you appoint to make decisions about your health care in the event that you are unable to make decisions yourself. You may specify to your agent what procedures you do or do not want, but this is not necessary. You can identify your health care agent in your living will or ask your lawyer to draft an official document needed to appoint a health care agent.

- **Durable power of attorney for health care.** This document allows you to designate a health care surrogate to make decisions for you even if you are temporarily unable to express your wishes. This can be part of a general durable power of attorney, which allows your surrogate to make decisions on your behalf in virtually all matters — legal, personal, and financial. This document must be drafted by a lawyer.

Share information with others

Whatever advance directives you select, give copies to your family and other caregivers, lawyer, physician, and other health care providers, and ask that they be made part of your permanent medical record.

If you have any questions about advance directives, speak with your lawyer.
Understanding mastectomy-related benefits

If you had a mastectomy or expect to have one, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). WHCRA is a federal law that requires group health plans and a health insurance issuer providing health insurance coverage in connection with a group health plan to cover breast reconstruction after a mastectomy. If you are receiving mastectomy-related benefits, you’ll have coverage — provided in a manner determined in consultation between you and your attending physician — for:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits are subject to the same deductibles, coinsurance, and/or copayments applicable to other medical and surgical benefits provided under your group health plan.
Evaluating new and emerging technologies

Every day, new technology is developed to fight disease. Many of these new products and procedures turn out to be highly effective, while some need further investigation. Many, however, fall short of their original intentions, and a few turn out to be unsafe or even harmful.

In an effort to provide coverage for safe and effective treatments, we evaluate new and emerging technologies for medical and behavioral health conditions. In accordance with accepted principles of technology assessment, we routinely evaluate the available evidence based on the following criteria:

The technology must have final approval from the appropriate government regulatory bodies. This applies when organizations like the U.S. Food and Drug Administration (FDA) regulate the lawful use of a product. It is important to remember that the evidence required for FDA approval varies depending on the type of product being reviewed.

The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations. These studies should be published in peer-reviewed journals. The quality and the consistency of the results are considered crucial in evaluating the evidence.

There should be evidence that the technology positively affects health outcomes. “Health outcomes” refers to the measurable physiologic responses of a medical nature.

The technology must improve the net health outcome. That means that the advantages outweigh the disadvantages.

The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as, or more than, established alternatives. Direct comparison of the technology with established standard treatments for the medical condition provides the best evidence.

The improvement must be attainable outside investigative settings. Participating professional providers with direct experience in the practice of the service help us evaluate the evidence. Their assessment helps us decide whether the service is an acceptable medical practice that should be available to members in our plans and networks.
Quality Management Program objectives

The Independence Blue Cross Quality Management (QM) Program monitors and objectively evaluates standards and quality of care for our members. The goals and objectives of the QM Program include the following:

- To improve the quality of medical and behavioral health care and service provided to members
- To maintain current preventive health and clinical practice guidelines
- To identify, develop, and/or enhance activities that promote member safety
- To comply with all regulatory requirements, and to achieve and maintain accreditation and necessary certification

For more information about our QM Program, visit ibx.com and select the Quality Management Program tab under Member Resources under the Individuals tab. You can also receive a printed copy of the QM goals and objectives by calling Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).
Safe prescribing of prescription drugs

Independence Blue Cross (Independence) offers members the Select Drug Program®. This is a formulary, or list of medications, including any restrictions and preferences, that includes all generic drugs and specific brand-name drugs approved by the U.S. Food and Drug Administration (FDA). The formulary is also reviewed by a group of physicians and pharmacists from the area who participate in our Pharmacy and Therapeutics (P&T) Committee. The P&T committee meets quarterly to review and update the formulary. Medications are reviewed by the committee for medical effectiveness, safety, and value before they are added to the formulary. You can find the formulary by clicking the PHARMACY button in ibxpress.com. You can also learn more about your prescription coverage by calling the Pharmacy Benefits telephone number on the back of your ID card.

Pharmacy benefits are managed by FutureScripts, an independent company that Independence contracts with to meet the pharmacy needs of our members, such as mail-order services for medications. Most of the time, medication requests, or claims, are processed upon receipt of a prescription from the prescriber. But there may be times that the physician will need to contact FutureScripts for medication coverage, as described in the Prescribing safety section below.

Generic medications

According to the FDA, generic medications are the same as brand-name medications in active ingredients, dosage, safety, strength, and performance, and are held to the same strict standards as brand-name medications. The only noticeable differences between a generic medication and a brand-name medication may be the shape and/or color. While generic medications are just as effective as brand-name medications, they may cost up to 70 percent less, which helps control health care costs. This helps you in the long run, because the generic option is always the lowest cost to you.

FutureScripts does not determine if a generic medication will be provided to you. In accordance with state laws, generic medications may be provided by the pharmacist, if available, unless the physician indicates “dispense as written” or “brand necessary” on the prescription. However, if brand-name medications are prescribed in place of a generic medication, prior authorization may be needed before the medication is covered. Prior authorization is explained in the Prescribing safety section below.

Medication tiers

The Select Drug Program is a tier-based program. The tiers are based on availability of generics and/or preferred status as identified by the P&T Committee. Most generic medications are covered under Tier 1, which have the least cost to the member. Preferred Brand medications are listed at Tier 2, which means there is a higher cost to the member than for a generic medication. Non-preferred medications are not included in the Select Drug Formulary, so they are covered at Tier 3. Tier 3 medications have the highest cost to the member. Please consult your Summary of Benefits for specific co-payment amounts or call the Customer Service number on the back of your ID card.

Exceptions

An exception is a request for a non-formulary medication to be covered at the formulary cost. Independence manages exceptions through the prior authorization process and the appeal process. A non-formulary exception process is available for members covered under the Select Drug Program. For a non-formulary medication to be covered at the formulary level, your doctor will need to submit the following supporting documentation and meet specific criteria:

- All formulary alternatives have been exhausted.
- There are contraindications to using the formulary alternatives.
- A completed Non-Formulary Exception Request form has been submitted by your provider and contains the following:
– Diagnosis for the drug requested
– Medication history
– Supporting medical information for the requested medication

Prescribing safety

Independence uses safe prescribing procedures to give you access to the drugs you need while keeping you safe. These procedures are designed to help you make the most of your prescription drug benefits by using them correctly. They are based on FDA guidelines and the criteria are endorsed by our P&T Committee. FutureScripts continuously monitors the effectiveness and safety of drugs and drug prescribing patterns. We support safe prescribing patterns with:

• Prior Authorization: A physician may order a medication that needs prior approval from the health plan before the medication will be covered. This is called prior authorization, and it is required of certain covered drugs to ensure that the drug prescribed is medically necessary, appropriate, and is being prescribed according to FDA guidelines. The approval criteria for these medications are developed and endorsed by the P&T Committee. These criteria may include that the physician order a trial of a different drug, such as a generic or a therapeutic alternative. Clinical pharmacists use these criteria to evaluate requests with the information submitted by the member’s prescribing physician and the member’s available prescription drug therapy history. Their review includes a review of drug interactions (also called contraindications) the appropriateness of dosing and length of therapy, and that other drug therapies, if necessary, were used where appropriate.

The prior authorization process may take up to two business days (24 hours for urgent requests) once the information from the prescribing physician has been received. Some drugs may have approval duration limits of six or 12 months. This means that after six or 12 months, the physician will need to ask for a new prior authorization. The prescriber is notified upon approval if limited approval duration exists. Physicians will fax the prior authorization form to FutureScripts for review, including all supporting medical information for the medication ordered.

• Age and gender limits: Upon approval of a drug, the FDA indicates specific safety limitations that govern prescription prescribing practices. These limits include age and/or gender limits that are designed to prevent potential harm to patients and to ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals age six and older, such as rizatriptan, or prescribed only for females, such as prenatal vitamins. The pharmacist’s computer provides up-to-date information about FDA rules. If the member’s prescription falls outside of the FDA guidelines, it will not be covered without prior authorization. The prescribing physician may request prior authorization when medically necessary. Otherwise, the member should ask the prescribing physician to request prior authorization. The approval criteria for this review were developed and endorsed by the P&T Committee.

• Quantity limits: Some drugs have a limit on how many doses you can receive per month. Quantity limits are based upon FDA-approved maximum daily doses and/or length of therapy of a particular drug. Quantity-level limits ensure that a drug is not taken in the wrong way and that you don’t take more than the FDA-approved maximum daily dose or length of therapy.
Pick a primary dentist
(HMO dental coverage only)

If you, or an eligible dependent, have dental coverage under your Keystone Health Plan East HMO group contract, you must select a primary dental office when you enroll. You may change your selection as often as once a month.

For assistance finding a network dentist near you, call Customer Service at 1-800-ASK-BLUE (TTY: 711) or go to ibx.com/findadoctor, and then select Dental Providers from the menu on the left.

Online directory features:

- Search by dentist or practice name, location, or specialty
- Compare dentists
- Get more information such as languages, ages treated, accepting new patients, gender, and handicap accessible
- View, print, download, and email personalized directories
- View and print a dentist’s location on a map and directions

Check your benefits description materials or ask your employer’s benefits administrator for additional information. Benefits may vary.

Find a dentist
1. Log on to ibx.com.
2. Select the Individuals tab and then select Find a Doctor.
3. Choose Dental Providers.
Using coverage when traveling (PPO)

We’re here for you whenever, wherever you need us. When it comes to your good health, we understand there are no geographic boundaries. With the BlueCard® and BlueCard Worldwide® programs, access to care is simply a phone call away.

<table>
<thead>
<tr>
<th>Overview</th>
<th>Who is eligible</th>
<th>How to access</th>
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</table>
| **BlueCard PPO** | All Independence Blue Cross (Independence) PPO members are eligible. | • Always carry your current ID card.  
• In an emergency, go to the nearest hospital.  
• To find names and addresses of nearby doctors and hospitals, call 1-800-810-BLUE or use the Find a Doctor tool at ibxpress.com.  
• Call Independence for prior authorization, if required. Refer to the telephone number on your ID card. |
| **BlueCard Worldwide** | All Independence PPO members are eligible. | • Always carry your current ID card.  
• To find a BlueCard Worldwide provider, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (within the United States) or visit ibx.com/bluecard. Outside the United States, call collect at 1-804-673-1177. Multilingual representatives are available 24 hours a day, 7 days a week, and can make an appointment with a doctor or arrange hospitalization, if necessary.  
• It is important that you call the BlueCard Worldwide Service Center for cashless access to inpatient care except for the usual out-of-pocket expenses (such as deductible or coinsurance). |

BlueCard Worldwide provides members with access to a worldwide network of hospitals and doctors on five continents. The program offers a wide range of medical assistance and claim support services for members traveling abroad, including:

• 24-hour international health care  
• A global network of providers  
• A website with travel health information  
• Translation assistance
Using your coverage when traveling (HMO, POS only)

We’re here for you whenever, wherever you need us. When it comes to your good health, we understand there are no geographic boundaries. With the BlueCard®, Away From Home Care®, and BlueCard Worldwide® programs, access to care is just a phone call away.

<table>
<thead>
<tr>
<th>Program overview</th>
<th>Who is eligible</th>
<th>How to access</th>
</tr>
</thead>
</table>
| **BlueCard* (PPO, HMO, and POS members)** | PPO, HMO, and POS members are eligible to take advantage of the program. | • Always carry your current ID card.  
• In an emergency, go to the nearest hospital.  
• To find names and addresses of nearby doctors and hospitals, call 1-800-810-BLUE or use the Find a Doctor tool at ibxpress.com.  
• Call Independence Blue Cross for prior authorization, if required. Refer to the telephone number on your ID card. |

**Away From Home Care (HMO and POS members)**

Away From Home Care is a value-added voluntary program providing HMO and POS group members with coverage for medical care, including routine treatment when visiting or living in another Blue Plan’s HMO operational area.

**Note:** The program is not available in some states.

**BlueCard Worldwide* (PPO, HMO, and POS members)**

BlueCard Worldwide provides members with access to a worldwide network of hospitals and doctors on five continents. The program offers a wide range of medical assistance and claim support services for members traveling abroad, including:

- 24-hour international health care
- A global network of providers
- A website with travel health information
- Translation assistance

PPO, HMO, and POS members are eligible to take advantage of the program.

- Always carry your current ID card.
- To find a BlueCard Worldwide provider, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (within the United States) or visit ibx.com/bluecard. Outside the United States, call collect at 1-804-673-1177. Multilingual representatives are available 24 hours a day, 7 days a week, and can make an appointment with a doctor or arrange hospitalization, if necessary.
- It is important that you call the BlueCard Worldwide Service Center for cashless access to inpatient care except for the usual out-of-pocket expenses (such as deductible or coinsurance).

*HMO and POS members are eligible only for emergency and urgent care services
Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

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Wellness recommendations to help you maintain your health

Health experts agree — and statistics have shown — that one way to help reduce your risk for illness is to follow recommended wellness practices such as:

- Visiting your health care provider for well-care visits and recommended health screenings
- Ensuring that immunizations (including flu, pneumonia, and whooping cough vaccinations) are up to date for you and your whole family
- Knowing your family’s medical history and discussing it with your health care provider.

You can find more information on well checkups and recommended health screenings at ibxpress.com. Select Member Resources under the Individuals tab at the top of the page, then pick Health & Wellness on the right side of the webpage. You can also obtain a printed copy of the Member Wellness Guidelines by calling the Health Resource Center at 1-800-ASK-BLUE. Remember to check your benefits coverage to learn more about which health screenings are covered and any costs involved.

Note: Your health care provider may suggest alternative tests/screenings to those listed. Wellness guidelines are constantly changing, and these guidelines were current at the time of publishing. Please discuss your individual needs relating to the recommended guidelines with your health care provider. Not all of the recommendations may be covered under your benefit program.
Improving health with your Wellness Profile

Are you looking for ways to improve your health but aren’t sure where to begin? Our interactive online Wellness Profile can help. The profile can help you:

- Identify and learn about possible health risks
- Identify opportunities for improving your overall well-being
- Connect with other resources

You can access your Wellness Profile by logging on to ibxpress.com and selecting Wellness Profile in the middle of the screen.

**Results provide an action plan for better health**

Once you complete your profile, you will receive an overall health score plus a summary report. The summary report shows your risks and what changes you can make to increase your score.

You will also receive risk reports, condition reports, and a Physician Summary. Risk reports provide a more in-depth look at some of your modifiable risk factors, such as diet, blood pressure, blood sugar, and emotional health. Condition reports show your personal risk for cancer, heart disease, stroke, and other diseases. The condition reports include information on early detection, next steps, and action plans.

Have questions about your results? Print out the Physician Summary and take it to your next office visit. Your doctor can offer additional suggestions for ways to improve your health.

You can get additional support and information by contacting our Registered Nurse Health Coaches. Health Coaches are available to you 24 hours a day, 7 days a week, to help you address general health questions and concerns. They can also work with you to help you improve your health or better manage your condition.

Nationally accepted guidelines and recommendations can change. To provide you with the most current health information available, content is regularly updated. We encourage you to complete your annually or as often as you wish.
Reaching a Health Coach with our 24/7 Health Information Line

When you have a chronic condition or a serious health concern, you may find it confusing or difficult to manage — juggling new medications, scheduling visits to doctors and specialists, and keeping information straight. That’s when an Independence Blue Cross Health Coach can help.

Health Coaches are registered nurses who are available to you via our Health Information Line 24 hours a day, 7 days a week, to help you with your health needs and questions. Once you speak with a Health Coach, he or she becomes your personal health resource for all your health-related issues. From information on chronic conditions to coordinating care and everything in between, your Health Coach is there to help you meet your health goals.

Call 1-800-ASK-BLUE (TTY: 711) to speak with a Health Coach. Translation services are available through the AT&T Language Line. There is no additional cost to you for using the Health Information Line.
Get support from a Registered Nurse
Health Coach

Living with a chronic condition or coordinating care after a hospital stay can be overwhelming, but you don’t have to do it alone. Independence Blue Cross (Independence) provides members with access to Health Coaches — registered nurses who are available 24/7 to help you manage your care and make informed health decisions — at no additional cost to you. Health Coaches are available 24 hours a day, 7 days a week, 365 days per year by calling 1-800-ASK-BLUE (TTY: 711).

Our Health Coaches support members with chronic conditions through our condition management program* and also members who require more intensive case management and coordination of care. Health Coaches have access to health information that may help identify members as being eligible for one of our programs. These members may receive a telephone call from a Health Coach offering support for their condition.

In addition, Health Coaches can address general health questions and concerns you may have. Once you speak with a Health Coach, he or she is dedicated to you. Whatever your health concern, your personal Health Coach works with you to set goals and develop a plan to manage your health care through telephone calls and/or educational materials and health reminders mailed to your home.

Together, you and your Health Coach will:

- Assess your current health status and history
- Confirm your needs and develop a care plan designed to meet your needs that could include home care, education, and coaching
- Review your plan and goals and communicate with your doctor as necessary

Speaking with a Health Coach is voluntary. You can talk with a Health Coach just once or establish a relationship and set up follow-up calls — whatever works best for you. If at any time you wish to stop your relationship with your Health Coach, simply call 1-800-ASK-BLUE and ask that you not be contacted by a Health Coach in the future.

*Condition management is available to most members. Please call Customer Service at the telephone number on your ID card to find out if you are eligible.
Accessing claims and benefit information online

As a member of an Independence Blue Cross (Independence) health plan, you have access to our secure, password-protected, self-service member website ibxpress.com.

One of the many features available on ibxpress.com is the ability to view personalized information about the benefits and services included in your coverage. To do so, select the Benefits tab, then Overview. There you will also find information about benefits and services not covered under your benefits plan, as well as copayments and other charges for which you may be responsible.

Using ibxpress.com, you can also view personalized information about the status of claims submitted for services provided for you by any provider in the network. By selecting Claims, you will be able to view the status of the claim, the date that the claim was paid, and any amount that you are responsible to pay.

If you have questions or need information about your claims or benefits coverage, or if you do not have Internet access, call Customer Service at 1-800-ASK-BLUE (TTY: 711).

Learn more about your benefits

As a member of Independence, you may have questions about your coverage and benefits. Our article database can provide answers. You can find the database at ibx.com/healtharticles.
Reaching multilingual Customer Service

If you or a member you know has difficulty communicating because of an inability to speak or understand English and needs language assistance, call Customer Service at 1-800-ASK-BLUE (for the hearing impaired: 711). Follow the prompts or wait to speak with a Customer Service representative.

Independence Blue Cross has multilingual staff, telephone language-line services, and TTY/TDD for the deaf or hearing impaired. Our Customer Service representatives can answer questions or provide information about your claims or benefits coverage. They can also assist you in finding a participating provider who speaks your language.
Manage your health plan on the go

Wherever you are, we’re there for you with online and mobile tools and resources that help you manage your benefits and make smarter health care decisions. Here’s how to get quick, secure access to your benefits information.

Log in at ibxpress.com

Your personalized member website is a one-stop destination where you can manage your health plan and learn about your benefits. Register and log in to ibxpress.com anytime and anywhere to:

- Find a doctor or hospital, rate your doctor, and read and write patient reviews
- View your claims, spending, and benefits information
- Print a temporary member ID card or request a new one
- Get access to valuable extras to help you stay well, including reimbursements on gym fees, health coaching, and discounts on fitness equipment, sporting events, and more.

All these tools and more are available to members on ibxpress.com and the IBX app available from the Apple App Store or Google Play store.

Get coverage news and reminders on your mobile phone

When you sign up for free, secure text messages* from IBX Wire™, you have a direct connection to your health plan through your mobile phone. Simply grab your ID card and call 1-888-700-1078 to sign up to receive timely text messages with:

- Important news about your coverage
- Reminders about important health screenings
- Special offers

* Standard message and data rates may apply.
Submitting a claim (HMO, POS, PPO only)

When you use a network provider, there’s no need for you to submit a claim. Your provider does that for you. However, if you are a Keystone Health Plan East (KHPE) POS or Direct POS member who self-refers to providers, or you are a Personal Choice PPO member using an out-of-network provider, you may be required to submit a claim form for services received. Here’s what to do:

If you’re a KHPE POS or Direct POS* member

You are required to submit a claim only for self-referred services. Use the POS claim form available when you log on to ibxpress.com.†

If you’re a Personal Choice PPO member

You may have to pay the full charges and then submit a claim for reimbursement if you use doctors or hospitals that:

• Are not in the Personal Choice network
• Are not in the BlueCard® PPO program
• Do not participate with any of the Blue Plans nationally

Out-of-network claim forms are available on ibxpress.com.

Step-by-step instructions

Claim submission instructions are located on the back of the KHPE POS, Direct POS, and Personal Choice PPO forms. Remember to always keep a copy of the completed claim form and the itemized bills for your records.

*KHPE POS and Direct POS members who use out-of-network doctors and hospitals may have to pay the full charges and then submit a claim form for reimbursement.

†Additional claim forms are available by calling Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).
Making an appeal or complaint (HMO, POS only)

Informal member complaint process

Keystone Health Plan East (KHPE) will make every attempt to address questions or concerns related to benefits or services. To discuss a concern or obtain the address to send a letter, call Customer Service at 1-800-ASK-BLUE (TTY: 711). Most member concerns are resolved informally at this stage. If we cannot immediately resolve your concern, we will investigate the issue and respond to you within 30 days. If you do not wish to wait for the response, you may file a formal complaint as outlined below.

Special appeal rules apply to federal and self-insured plans. These rules are not described here. Federal enrollees and enrollees of self-insured plans should consult their benefits description materials for details.

Member appeals

The two types of member appeals — complaints and grievances — are classified as “preservice” or “postservice.” A preservice appeal is for services that are covered only if preapproved by KHPE before medical care is obtained. A postservice appeal is for other claims when KHPE preapproval is not required and medical care has already been rendered. Also, expedited review is available for appeals that involve “urgent care” — any appeal for medical care or treatment with respect to which the application of the time periods for making nonurgent determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the appeal.

The member appeal process for complaints and grievances consists of up to two levels of internal appeal for group plans (only one level of internal appeal for nongroup plans) and one level of external appeal. KHPE completes the internal review and issues decision letters with further appeal rights within the following time frames:

- **Standard appeals:**
  - Group plans: from receipt of first- or second-level appeal request — 15 days for preservice; 30 days for postservice
  - Individual plans: from receipt of first-level appeal request — 30 days for preservice; 60 days for postservice
- **Expedited appeals:** from receipt of a qualified urgent care appeal request — 48 hours

Claimants with urgent care conditions or who are currently receiving ongoing treatment may file an external expedited review at the same time they file an internal expedited review by calling Customer Service at 1-800-ASK-BLUE (TTY: 711).

KHPE will provide to the member, free of charge, new or additional evidence considered, relied upon, or generated by KHPE in connection with the appeal sufficiently in advance of notice of the internal adverse determination to give the member reasonable opportunity to respond.

To file a member complaint or grievance appeal, write as directed in the KHPE notice or call Customer Service at 1-800-ASK-BLUE (TTY: 711). With your valid consent, your provider or another authorized representative may appeal on your behalf.
Appeal committees

Each appeal committee consists of one or more persons designated to act as decision-maker. The decision-makers may not have participated in the previous decision to deny coverage, and they are not subordinates of whoever made that determination.

Each committee reviews all information for the appeal provided by the member or other sources. For grievances, the first-level decision-maker is a plan medical director who is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist, or “same or similar specialty physician,” is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review.

Internal review process for member complaint appeals

A member complaint appeal focuses on an unresolved dispute or objection regarding coverage related to contract exclusions/limitations, noncovered services, cost-sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions or the operations or management policies of KHPE). First-level complaint appeals must be filed within 180 days after receipt of the notice that you dispute or completion of the informal complaint process.

A committee consisting of one KHPE staff person decides first-level complaints within the applicable period. For group plans, second-level complaint appeals are to be filed within 60 days after receipt of the first-level appeal decision letter. A three-person committee, consisting of two staff persons familiar with managed care and one nonemployee, decides second-level complaint appeals.

Internal review process for member grievance appeals based on medical necessity decisions

A member grievance appeal focuses on a KHPE decision to deny, reduce, or limit coverage that is based on an evaluation of the medical necessity or appropriateness of the coverage request. First-level member grievance appeals must be filed within 180 days after receipt of the adverse benefit determination. A plan medical director decides a first-level grievance within the applicable period. For group plans, standard second-level grievance appeals are to be filed within 60 days after receipt of the related first-level decision letter. However, an expedited grievance appeal has only one level of internal review, which is to be completed within 48 hours after receipt of a qualified appeal request for urgent care.

A three-person committee, consisting of a medical director, another staff person familiar with managed care, and one nonemployee, decides expedited grievance appeals and standard second-level grievance appeals.

External member appeal process

Once an internal appeal review is completed, the external appeal process for complaints and grievances varies from plan to plan. To file an external complaint or grievance appeal, follow the directions stated in the KHPE letter that provides notice of the decision on the final level of the internal appeal review.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal, you may have the right to bring civil action under Section 502(a) of the act. For questions about your rights and this notice, or for assistance, you can call the Employee Benefits Security Administration at 1-866-444-EBSA. In addition, for insured plans, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388
insurance.pa.gov
If your health plan fails to “strictly adhere” to the internal appeal process, you may initiate an external review or file appropriate legal action under state law or ERISA, unless the violation:

- Was de minimis (minimal)
- Did not cause (or was not likely to cause) prejudice or harm to the claimant
- Was for good cause or due to matters beyond the control of the insurer/plan
- Was in the context of a good faith exchange of information with the claimant
- Was not part of a pattern or practice of violations

Note: The procedures summarized here vary based on plan type and may change due to changes in applicable state and federal laws, to satisfy standards of certain recognized accrediting agencies, or to improve the member appeal process. For additional information, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).
Making an appeal or complaint (PPO)

Informal member complaint process

Personal Choice (the “Plan”) will make every attempt to address questions or concerns related to benefits or services. To discuss a concern or obtain the Plan address to send a letter, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711). Most member concerns are resolved informally at this stage. If we cannot immediately resolve your concern, we will investigate the issue and respond to you within 30 days. If you do not wish to wait for the response, you may file a formal appeal as outlined below.

Special appeal rules apply to federal and self-insured plans. These rules are not described here. Federal enrollees and enrollees of self-insured plans should consult their benefits description materials for details.

Member appeals

The two types of member appeals — administrative and medical necessity — are classified as “preservice” or “postservice.” A preservice appeal is for services that are covered only if precertified by the Plan before medical care is obtained. A postservice appeal is for other claims when Plan precertification is not required and medical care has already been rendered. Also, an expedited review is available for appeals that involve “urgent care” — any appeal for medical care or treatment with respect to which the application of the time periods for making nonurgent determinations could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member’s medical condition, would subject the member to severe pain that cannot adequately be managed without the care or treatment that is the subject of the appeal.

The member appeal process consists of up to two levels of internal appeal for members with group coverage and only one level of internal appeal for members with individual coverage. Both group and individual coverage have one level of external review for reasons of medical necessity or rescission of coverage (except for nonpayment of premiums). The Plan completes the internal review and issues decision letters stating any further appeal rights within the following time frames:

- **Standard appeals:**
  - **Group plans:** from receipt of first- or second-level appeal request — 15 days for preservice; 30 days for postservice
  - **Individual plans:** from receipt of first-level appeal request — 30 days for preservice; 60 days for postservice

- **Expedited appeals:** from receipt of a qualified urgent care appeal request — 72 hours

Claimants with urgent care conditions or who are currently receiving ongoing treatment may file an external expedited review at the same time they file an internal expedited review by calling Customer Service at 1-800-ASK-BLUE (TTY: 711).

The Plan will provide to the member, free of charge, new or additional evidence considered, relied upon, or generated by the Plan in connection with the appeal sufficiently in advance of notice of the internal adverse determination to give the member reasonable opportunity to respond.

To file a member appeal on an administrative or medical necessity issue, write as directed in the Plan notice or call Customer Service at 1-800-ASK-BLUE (TTY: 711). With your valid consent, your provider or another authorized representative may appeal on your behalf.

Learn more about your benefits

As a member of an Independence health plan, you may have questions about your coverage and benefits. Our article database can provide answers. You can find the database at ibxpress.com/healtharticles.
Appeal committees

Each appeal committee consists of one or more persons designated to act as decision-maker. The decision-makers may not have participated in the previous decision to deny coverage, and they are not subordinates of whoever made that determination.

Each committee reviews all information provided by the member or other sources. For first-level medical necessity appeals, the decision-maker is a plan medical director who is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist, or “same or similar specialty physician,” is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review.

Internal review process for member administrative appeals

A member administrative appeal focuses on an unresolved dispute or objection, including coverage related to contract exclusions/limitations, noncovered services, cost-sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions). First-level administrative appeals must be filed within 180 days after receipt of the notice that you dispute or completion of the informal complaint process. A committee consisting of one Plan staff person familiar with managed care decides first-level administrative appeals within the applicable period. For group plans, second-level administrative appeals are to be filed within 60 days after receipt of the first-level appeal decision letter. A committee of one to three staff persons familiar with managed care decides second-level administrative appeals.

Internal review process for member medical necessity appeals

A member medical necessity appeal focuses on a Plan decision to deny, reduce, or limit coverage that is based on an evaluation of the medical necessity or appropriateness of the coverage request. First-level member medical necessity appeals must be filed within 180 days after receipt of the adverse benefit determination. For group plans, standard second-level medical necessity appeals are to be filed within 60 days after receipt of the related first-level decision letter. An expedited medical necessity appeal has only one level of internal review, which is to be completed within 72 hours after receipt of a qualified appeal request for urgent care. A committee of one to three staff persons familiar with managed care, including a medical director, decides expedited medical necessity appeals and, for group plans, second-level medical necessity appeals.

External member appeal process

After the internal appeal review is completed, the external review process available for medical necessity and administrative appeals varies from plan to plan. To file an external review, follow the directions stated in the Plan letter that provides notice of the decision on the final level of the internal appeal review. If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal, you may have the right to bring civil action under Section 502(a) of the act. For questions about your rights and this notice, or for assistance, you can call the Employee Benefits Security Administration at 1-866-444-EBSA. In addition, for insured plans, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388
insurance.pa.gov
If your health plan fails to “strictly adhere” to the internal appeal process, you may initiate an external review or file appropriate legal action under state law or ERISA, unless the violation:

- Was *de minimis* (minimal)
- Did not cause (or was not likely to cause) prejudice or harm to the claimant
- Was for good cause or due to matters beyond the control of the insurer/plan
- Was in the context of a good faith exchange of information with the claimant
- Was not part of a pattern or practice of violations

**Note:** The procedures summarized here vary by plan type and may change due to changes in applicable state and federal laws, to satisfy standards of certain recognized accrediting agencies, or to improve the member appeal process. For additional information, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).
Making an appeal or complaint  
(National BlueCard® PPO)

Informal member complaint process

Independence Blue Cross (Independence) will make every attempt to address questions or concerns related to benefits or services. To discuss a concern or obtain the address to send a letter, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711). Most member concerns are resolved informally at this stage. If we cannot immediately resolve your concern, we will investigate the issue and respond to you within 30 days. If you do not wish to wait for the response, you may file a formal appeal as outlined below.

Special appeal rules apply to federal and self-insured plans. These rules are not described here. Federal enrollees and enrollees of self-insured plans should consult their benefits description materials for details.

Member appeals

The two types of member appeals — administrative and medical necessity — are classified as “preservice” or “postservice.” A preservice appeal is for services that are covered only if precertified by the Plan before medical care is obtained. A postservice appeal is for other claims when Plan precertification is not required and medical care has already been obtained. Also, expedited review is available for appeals that involve “urgent care” — any appeal for medical care or treatment with respect to which the application of the time periods for making nonurgent 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 adequately be managed without the care or treatment that is the subject of the appeal.

The member appeal process for administrative and medical necessity issues consists of up to two levels of internal appeal. The Plan completes internal review and issues decision letters stating any further appeal rights within the following time frames:

- **Standard appeals:** from receipt of first- or second-level appeal request — 15 days for preservice; 30 days for postservice
- **Expedited appeals:** from receipt of a qualified urgent care appeal request — 72 hours

Claimants with urgent care conditions or who are currently receiving ongoing treatment may file an external expedited review at the same time they file an internal expedited review by calling Customer Service at 1-800-ASK-BLUE (TTY: 711).

The Plan will provide to the member, free of charge, new or additional evidence considered, relied upon, or generated by Independence in connection with the appeal sufficiently in advance of notice of the internal adverse determination to give the member reasonable opportunity to respond.

To file a member appeal on an administrative or medical necessity issue, write as directed in the Plan notice or call Customer Service at 1-800-ASK-BLUE (TTY: 711). In addition, with your valid consent, your provider or another authorized representative may appeal on your behalf.

Appeal committees

Each appeal committee consists of one or more persons designated by the Plan to act as decision-maker. The decision-makers may not have participated in the previous decision to deny coverage and are not subordinates to whomever made that determination.

Each committee reviews all information provided by the member or other sources. For medical necessity appeals, the first-level decision-maker is a plan medical director who is a matched specialist or the decision-maker receives input from a consultant who is...
a matched specialist. A matched specialist, or “same or similar specialty physician,” is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review.

For expedited and second-level appeals, members or their authorized representatives may make a brief presentation to the committee in person or by telephone conference call.

**Internal review process for member administrative appeals**

A member administrative appeal focuses on an unresolved dispute or objection, including coverage related to contract exclusions/limitations, and noncovered services, cost-sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions). First-level administrative appeals must be filed within 180 days after receipt of the notice that you dispute or completion of the informal complaint process.

A committee consisting of one Plan staff person familiar with managed care decides first-level administrative appeals within the applicable period. Second-level administrative appeals are to be filed within 60 days after receipt of the first-level appeal decision letter. A committee of one to three staff persons familiar with managed care decides second-level administrative appeals.

**Internal review process for member medical necessity appeals**

A member medical necessity appeal focuses on a Plan decision to deny, reduce, or limit coverage that is based on an evaluation of the medical necessity or appropriateness of the coverage request.

First-level member medical necessity appeals must be filed within 180 days after receipt of the adverse benefit determination.

A plan medical director decides standard first-level medical necessity appeals within the applicable period. Standard second-level medical necessity appeals are to be filed within 60 days after receipt of the related first-level decision letter. An expedited medical necessity appeal has only one level of internal review, which is to be completed within 72 hours after receipt of a qualified appeal request for urgent care. A committee of one to three staff persons familiar with managed care, including a medical director, decides expedited medical necessity appeals and standard second-level medical necessity appeals.

**External member appeal process**

After the internal appeal review is completed, an external appeal process is available for issues related to medical judgment and rescission of coverage (except for nonpayment of premiums). To file an external appeal, follow the directions stated in the letter that provides notice of the decision on the final level of the internal appeal review.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal, you may have the right to bring civil action under Section 502(a) of the act. For questions about your rights and this notice, or for assistance, you can call the Employee Benefits Security Administration at 1-866-444-EBSA.

**Note:** The procedures summarized above are for plans that are not grandfathered under health care reform. Plans do vary by plan type and may change due to changes in applicable state and federal laws, to satisfy standards of certain recognized accrediting agencies, or to improve the member appeal process. For additional information regarding your specific plan benefits, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).
Making an appeal or complaint (Traditional/CMM)

Informal member complaint process

Independence Blue Cross (Independence) will make every attempt to address questions or concerns related to benefits or services. To discuss a concern or obtain the address to send a letter, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711). Most member concerns are resolved informally at this stage. If we cannot immediately resolve your concern, we will investigate the issue and respond to you within 30 days. If you do not wish to wait for the response, you may file a formal appeal as outlined below.

Special appeal rules apply to federal and self-insured plans. These rules are not described here. Federal enrollees and enrollees of self-insured plans should consult their benefits description materials for details.

Member appeals

The two types of member appeals — administrative and medical necessity — are classified as “preservice” or “postservice.” A preservice appeal is for services that are covered only if precertified by the Plan before medical care is obtained. A postservice appeal is for other claims when Plan precertification is not required and medical care has already been obtained. Also, expedited review is available for appeals that involve “urgent care” — any appeal for medical care or treatment with respect to which the application of the time periods for making nonurgent 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 adequately be managed without the care or treatment that is the subject of the appeal.

The member appeal process for administrative and medical necessity issues consists of one level of internal appeal and one level of external review. The external review is for reasons of medical necessity or rescission of coverage (except for nonpayment of premiums). The Plan completes internal review and issues decision letters stating any further appeal rights within the following time frames:

- **Standard appeals**: from receipt of appeal request — 30 days for preservice; 60 days for postservice
- **Expedited appeals**: from receipt of a qualified urgent care appeal request — 72 hours

Claimants with urgent care conditions or who are currently receiving ongoing treatment may file an external expedited review at the same time they file an internal expedited review by calling Customer Service at 1-800-ASK-BLUE (TTY: 711).

The Plan will provide to the member, free of charge, new or additional evidence considered, relied upon, or generated by Independence in connection with the appeal sufficiently in advance of notice of the internal adverse determination to give the member reasonable opportunity to respond.

To file a member appeal on an administrative or medical necessity issue, write as directed in the Plan notice or call Customer Service at 1-800-ASK-BLUE (TTY: 711). In addition, with your valid consent, your provider or another authorized representative may appeal on your behalf.

Appeal committees

Each appeal committee consists of one or more persons designated by the Plan to act as decision-maker. The decision-makers may not have participated in the previous decision to deny coverage and are not subordinates to whomever made that determination.
Each committee reviews all information provided by the member or other sources. For medical necessity appeals, the decision-maker is a plan medical director who is a matched specialist or the decision-maker receives input from a consultant who is a matched specialist. A matched specialist, or “same or similar specialty physician,” is a licensed physician or psychologist who is in the same or similar specialty as typically manages the care under review. For expedited appeals, members or their authorized representatives may make a brief presentation to the committee in person or by telephone conference call.

Internal review process for member administrative appeals

A member administrative appeal focuses on an unresolved dispute or objection including coverage related to contract exclusions/limitations, noncovered services, cost-sharing requirements, and rescission of coverage (except for failure to pay premiums or coverage contributions). Administrative appeals must be filed within 180 days after receipt of the notice that you dispute or completion of the informal complaint process.

A committee consisting of one Plan staff person familiar with managed care decides administrative appeals within the applicable period.

Internal review process for member medical necessity appeals

A member medical necessity appeal focuses on a Plan decision to deny, reduce, or limit coverage that is based on an evaluation of the medical necessity or appropriateness of the coverage request. Member medical necessity appeals must be filed within 180 days after receipt of the adverse benefit determination.

A plan medical director decides standard medical necessity appeals within the applicable period. An expedited medical necessity appeal has only one level of internal review, which is to be completed within 72 hours after receipt of a qualified appeal request for urgent care. A committee of one to three staff persons familiar with managed care, including a medical director, decides expedited medical necessity appeals.

External member appeal process

After the internal appeal review is completed, an external appeal process is available for both medical necessity and administrative appeals. External review is for reasons of medical necessity or rescission of coverage (except for nonpayment of premiums).

To file an external appeal, follow the directions stated in the letter that provides notice of the decision on the standard internal appeal review.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal, you may have the right to bring civil action under Section 502(a) of the act. For questions about your rights and this notice, or for assistance, you can call the Employee Benefits Security Administration at 1-866-444-EBSA. In addition, if you have an insured business, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388
insurance.pa.gov

If your health plan fails to “strictly adhere” to the internal appeal process, you may initiate an external review or file appropriate legal action under state law or ERISA unless the violation:

- Was de minimis (minimal)
- Did not cause (or was not likely to cause) prejudice or harm to the claimant
- Was for good cause or due to matters beyond the control of the insurer/plan
• Was in the context of a good faith exchange of information with the claimant
• Was not part of a pattern or practice of violations

Note: The procedures summarized above are for plans that are not grandfathered under Health Care Reform. Plans do vary by plan type and may change due to changes in applicable state and federal laws, to satisfy standards of certain recognized accrediting agencies, or to improve the member appeal process. For additional information regarding your specific plan benefits, call Customer Service at 1-800-ASK-BLUE (1-800-275-2583; TTY: 711).