1901 Market Street
Philadelphia, PA 19103-1480

Independence

PAISBOA Health Benefit Trust
301 Iven Avenue Ste 315B
Wayne, PA 19087

July 30, 2026

Re: Your Keystone Health Plan East
Benefit Program

Dear Administrator:
Enclosed is a copy of the benefit booklet(s) that outlines the benefit program currently administered by Independence Blue Cross. The attached booklet(s) serves to document the benefit program agreement reached between us.

For our records, please indicate your acceptance of the benefit program outlined in the booklet(s) by signing, where indicated below, and returning this page to us within ten (10) days of your receipt of this letter. This signed acceptance page should be returned to:

Independence Blue Cross
Contract and Booklet Department, 33rd Floor
Attn: Charles Cauthorn
1901 Market Street
Philadelphia, PA 19103

If it is more convenient, you may alternately choose to fax this signed acceptance page to us at 215-241-4428.

We look forward to continuing our business relationship with you. If any questions or problems should arise regarding your benefit program, please call your Independence Blue Cross Marketing Executive.

Sincerely,

Koleen A. Cavanaugh

Printed Name: **Koleen Cavanaugh**
Title: SVP and Chief Marketing Executive

Enc.

Agreed to and Accepted:

Name: _____

Date: _____

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

16887

HMO

GROUP HEALTH MAINTENANCE ORGANIZATION

BENEFITS BOOKLET

KEYSTONE HEALTH BENEFITS PLAN

Administered by

Keystone Health Plan East, Inc.
("Keystone" or "the Claims Administrator")*
*independent corporation operating under a license
from Blue Cross and Blue Shield Association

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

Your health benefits are entirely funded by your employer. Keystone Health Plan East, Inc. provides administrative and claims payment services only.

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

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

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 1-800-275-2583 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discrimination Is Against the Law

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

This plan:

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

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

If you believe that this Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: our Civil Rights Coordinator, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: **civilrightscoordinator@1901market.com**.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

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INTRODUCTION

Welcome to the Health Benefits Plan established by the Group and administered by "Keystone Health Plan East, Inc. ("Keystone" or "the Claims Administrator") . Keystone has entered into an arrangement with the Group to provide claims administration services and to make its Provider networks available for this Program.

This Benefit Booklet is a description of the terms, conditions and procedures required to be followed in order to receive the benefits and Covered Services to which the Member is entitled. Covered Services are described in the ***Description of Covered Services*** section of this Benefit Booklet. Benefits, exclusions and Limitations appear in the ***Exclusions – What Is Not Covered*** and the ***Schedule Of Covered Services*** section of this Benefit Booklet.

If changes are made to this Program, the Member will be notified. Changes will apply to benefits for services received on or after the effective date unless otherwise required by applicable law.

The effective date is the *later* of:

- The effective date of the change;
- The Member's Effective Date of coverage; or
- The Administrative Services Only Agreement anniversary date coinciding with or next following that service's effective date.

Please read this Benefit Booklet thoroughly and keep it handy. It will answer most questions regarding the Claims Administrator's procedures and services.
If Members have any questions, they should contact their Plan Administrator or call the Customer Service Department ("Customer Service") at the telephone number shown on the Member's Identification Card ("ID Card").

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

See ***Important Notices*** section for updated language and coverage changes that may affect this Benefit Booklet.

Your Costs

Benefit Period	Agreement Year (12 month period beginning on Group's anniversary date)
Out-Of-Pocket Maximum	
Per Member	$6,350
Per Family	$12,700

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

If the Member has met the Out-of-Pocket Maximum in this Benefit Period and their Provider continues to ask for cost sharing, the Member should contact Customer Service.

This maximum includes Copayments required under the Vision benefit, if made a part of this Program.

Lifetime Benefit Maximum	Unlimited

SCHEDULE OF COVERED SERVICES

The Member is entitled to benefits for the Covered Services described in their Benefit Booklet, subject to any Coinsurance, Copayment, or Limitations described below.

If the Participating Provider's usual fee for a Covered Service is less than the Coinsurance or Copayment shown in this schedule, the Member is only responsible to pay the Participating Provider's usual fee. The Participating Provider is required to remit any Coinsurance or Copayment overpayment directly to the Member. Contact Customer Service at the phone number on the Member ID Card with any questions regarding this.

The Member's Primary Care Physician or Specialist must obtain Preapproval from the Claims Administrator to confirm this Program's coverage for certain Covered Services. If the Member's Primary Care Physician or Specialist provides a Covered Service or Referral without obtaining the Claims Administrator's Preapproval, the Member is not responsible for payment for that Covered Service. The Member can access a complete list of services that require Preapproval by logging onto www.ibx.com/preapproval, or by calling Customer Service at the phone number listed on the Member ID Card to have the list mailed to them.

BENEFIT	COST SHARING
Acupuncture[4]	$50 Copayment per visit
Note for Acupuncture shown above: Benefit Period maximum: 18 visits	
Alcohol Or Drug Abuse And Dependency Treatment[3] (Including Detoxification Services)	
Inpatient	$400 Copayment per day, to a maximum of 5 Copayments per admission*
Outpatient	
Office Visit	$50 Copayment per visit/session
All Other	$50 Copayment per visit/session
Telebehavioral Health	$50 fee per Provider per date of service
Ambulance Services/Transport[4]	
Emergency	None
Non-Emergency	None
Autism Spectrum Disorders[4]	Same cost-sharing as any other Covered service within the applicable medical service category (For example, Specialist, Hospital Services, Therapy Services, etc.)
Note for Autism Spectrum Disorders shown above:	
Visit limits do not apply to services provided for this condition.	
If this Program does not provide coverage for Prescription Drugs, Autism Spectrum Disorders medications are covered less the applicable Coinsurance per 30 day Prescription Order:	
Generic Coinsurance - 30% of the retail pharmacy price	Brand Coinsurance - 30% of the retail pharmacy price
Blood[3]	None
Day Rehabilitation Program[4]	None
Note for Day Rehabilitation Program shown above: Benefit Period maximum: 30 visits	
Diabetic Education Program[4]	None
Note for Diabetic Education Program shown above: Copayments, Coinsurance and maximum amounts do not apply to this benefit.	
Diabetic Equipment And Supplies[4]	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
Diagnostic Services - Non-Routine[4] (including MRI/MRA, CT scans, PET scans, Sleep Studies	$100 Copayment per date of service
Diagnostic Services - Routine[4] (including Allergy Testing)	$50 Copayment per date of service
Durable Medical Equipment and Consumable Medical Supplies[4]	50% of the contracted fee schedule amount for a Durable Medical Equipment Provider
Note for Durable Medical Equipment and Consumable Medical Supplies shown above: Cost-sharing does not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.	

BENEFIT	COST SHARING
Emergency Services - Facility[4]	$150 Copayment per date of service (waived if admitted)
Note for Emergency Services shown above: The emergency room Copayment will be the PCP Office Visit Copayment if the Member notifies us that they were directed to the emergency room by their Primary Care Physician or the Claims Administrator, and the services could have been provided in their Primary Care Physician's office.	
Gender Dysphoria and Sexual Reassignment Therapy[4]	None
Home Health Care[4]	None
Hospice Services[3]	
Inpatient Hospice Service	None
Outpatient Hospice Services	
Professional Service	None
Facility Service for Respite Care	None
Note for Hospice Services shown above: Respite Care: Maximum of seven days every six months	
Hospital Services[2]	$400 Copayment per day, to a maximum of 5 Copayments per admission*
Immunizations[1]	None
Injectable Medications[4]	
Biotech/Specialty Injectable Drugs	
Home/Office	None
Outpatient	$100 Copayment per injection
Standard Injectable Drugs (including Allergy Injections)	None
Note for Injectable Medications shown above: The cost-sharing amounts for injected or infused drugs set forth above are applicable to those injected or infused drugs administered to a Member who does not receive cost-sharing assistance such as coupons/copay cards provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member's Deductible, if applicable, or Out-of-Pocket Maximum. Additionally, the HMO may elect to implement a program whereby each separate injected or infused drug will be paid by the HMO subject to variable copayment amounts. This variable copayment amount associated with an injected or infused drug or for certain other high-cost injected or infused drugs experienced by a Member will not result in a Member paying more cost-sharing out of pocket for an injected or infused drug than they would have paid absent the HMO's application of the program. Members who exhaust cost-sharing assistance available from a manufacturer will not be responsible for more cost-sharing for the drug or refill than the amount for which they were responsible while receiving such cost-sharing assistance.	
Insulin And Oral Agents[4]	None, less the Copayment amount, if applicable
Laboratory and Pathology Tests[4]	None

BENEFIT	COST SHARING
Maternity/OB-GYN/Family Services[3]	
Artificial Insemination	None
Elective Abortions	
Professional Service	$30 Copayment per visit
Outpatient Facility Charges	$200 Copayment per Outpatient surgical procedure performed
Hospital-Based Facility	$200 Copayment per Outpatient surgical procedure performed
Maternity / Obstetrical Care	
Professional Service	None
Facility Service-Inpatient/Birthing Center	$400 Copayment per day, to a maximum of 5 Copayments per admission*
Newborn Care	$400 Copayment per day, to a maximum of 5 Copayments per admission*
Ovulation Induction	None
Medical Care[2]	None
Medical Foods And Nutritional Formulas[4]	None
Mental Health Care and Serious Mental Illness Health Care [3]	
Inpatient	$400 Copayment per day, to a maximum of 5 Copayments per admission*
Outpatient	
Office Visit	$50 Copayment per visit/session
All Other	$50 Copayment per visit/session
Methadone Treatment[3]	None
Nutrition Counseling[1]	None
Note for Nutrition Counseling shown above: Benefit Period maximum: 6 visits/sessions. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.	
Preventive Care – Adult[1]	None
Routine/Preventive Colonoscopy	
Preventive Plus (P+) Facility/Non-Hospital-Based Facility**	None
Non-Preventive Plus (P+) Facility/Hospital-Based Facility*	None

BENEFIT	COST SHARING
*The Hospital-Based Copayment will be waived if your Primary Care Physician determines that it would be medically inappropriate to have the preventive colonoscopy service provided in the ambulatory setting. **For $0 (None) Member cost-sharing to apply, all services must be performed by a Participating gastroenterologist or a colon and rectal surgeon. *Note for Routine/Preventive Colonoscopy shown above:* There is no cost share applied if your preventive colonoscopy service is performed at a facility that is not Hospital-Based (for example, an Ambulatory Facility); if your preventive colonoscopy service is performed at a Hospital-Based facility, the Hospital-Based copayment shown above will apply. In addition to seeking services from Preventive Plus Providers, colonoscopy screenings must meet the United States Preventive Services Task Force's (USPSTF) guidelines for $0 (None) Member cost sharing to apply.	
Preventive Care - Pediatric[1]	None
Primary Care Physician Office Visits/Retail Clinic - Non-Preventive[1] (Includes Home Visits and Outpatient Consultations)	$30 Copayment per visit
Private Duty Nursing Services[1]	20% of the Participating Provider's contracted fee schedule amount
Note for Private Duty Nursing Services shown above: Benefit Period maximum: 360 hours	
Prosthetic Devices[4]	None
Skilled Nursing Facility Services[2]	$200 Copayment per day, to a maximum of 5 Copayments per admission*
Note for Skilled Nursing Facility Services shown above: Benefit Period maximum: 120 Inpatient days. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment for Alcohol or Drug Abuse and Dependency.	
Smoking Cessation[1]	None
Specialist Office Visits[4]	$50 Copayment per visit
Spinal Manipulation Services[4]	$50 Copayment per date of service per Provider
Note for Spinal Manipulation Services shown above: Benefit Period maximum: 20 visits	
Surgical Services[3]	
Outpatient Facility Service	$200 Copayment per Outpatient surgical procedure performed
Hospital-Based Facility	$200 Copayment per Outpatient surgical procedure performed
Outpatient Anesthesia	None

BENEFIT	COST SHARING
Second Surgical Opinion (Voluntary)	$50 Copayment per opinion
Note for Surgical Services shown above: If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Claims Administrator will pay 100% of the contracted fee schedule amount, less any required Member Copayments for the highest paying procedure and 50% of the contracted fee schedule amount for each additional procedure. Note for Surgical Services shown above: Cost-sharing does not apply to Outpatient Surgery services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.	
Therapy Services[(4)]	
Cardiac Rehabilitation Therapy	$50 Copayment per date of service per Provider
Note for Cardiac Rehabilitation Therapy shown above: Benefit Period maximum: 36 sessions	
Chemotherapy	None
Dialysis	None
Infusion Therapy	
Home/Office	None
Outpatient	$100 Copayment per date of service per Provider
Orthoptic/Pleoptic Therapy	$50 Copayment per date of service per Provider
Note for Orthoptic/Pleoptic Therapy shown above: Lifetime maximum: 8 sessions	
Physical Therapy/Occupational Therapy	$50 Copayment per date of service per Provider
Note for Physical Therapy/Occupational Therapy shown above: Benefit Period maximum: 30 sessions. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment for Alcohol or Drug Abuse and Dependency. Benefit Period maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.	
Pulmonary Rehabilitation Therapy	$50 Copayment per date of service per Provider
Note for Pulmonary Rehabilitation Therapy shown above: Benefit Period maximum: 36 sessions	
Radiation Therapy	None
Speech Therapy	$50 Copayment per date of service per Provider
Note for Speech Therapy shown above: Benefit Period maximum: 20 sessions. Benefit Period maximums do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment for Alcohol or Drug Abuse and Dependency.	

BENEFIT	COST SHARING
Transplant Services[3] Blue Distinction Center and Blue Distinction+ Centers only	Applicable Inpatient or Professional Provider Copayments or Coinsurance will apply
Travel and Lodging[4]	None
Note for Travel and Lodging shown above: Travel Lifetime Maximum: $10,000 of Covered Services per Member. Lodging Covered Services are limited to $50 per Member, per night (up to $100, if a companion travels).	
Urgent Care Centers[4]	$50 Copayment per visit
Women's Preventive Care[1]	None
Note for Women's Preventive Care shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained at a Participating Pharmacy or a Participating Mail Service Pharmacy for certain generic products and brand products. All other contraceptive products are covered at standard cost-sharing as reflected in this *Schedule of Covered Services*	

BENEFIT	FOR BENEFITS PROVIDED BY CONTRACTED VENDOR:
Virtual Care Services[4]	
Telemedicine Visit (Vendor/Virtual Provider)	Covered
Teledermatology	Not Covered
Telebehavioral Health	Covered
Telemedicine services are provided through Doctor on Demand. Please refer to Doctor on Demand materials for additional information about coverage and member cost sharing.	

Inpatient Copayment Waiver Provision
*If an Inpatient Copayment is shown in this schedule, it applies to each admission, readmission or transfer of a Member for Covered Services for Inpatient treatment of any condition. For purposes of calculating the total Copayment due, any admission occurring within ten days of discharge from any previous admission shall be treated as part of the previous admission.

(1) Located in the Primary & Preventive Care section of the ***Description of Covered Services***
(2) Located in the Inpatient section of the ***Description of Covered Services***
(3) Located in the Inpatient/Outpatient section of the ***Description of Covered Services***
(4) Located in the Outpatient section of the ***Description of Covered Services***

DESCRIPTION OF COVERED SERVICES

Subject to the Exclusions, conditions and Limitations of this Program, a Member is entitled to benefits for the Covered Services described in this ***Description of Covered Services*** section. The Member may be responsible for applicable cost sharing or there may be limits on services as specified in the ***Schedule of Covered Services*** section of the Benefit Booklet. Additional benefits may be provided by the Group through the addition of a Rider. If applicable, this benefit information is also included with this Benefit Booklet. Please take time to read this ***Description of Covered Services*** and the ***Schedule of Covered Services***, and use them as references whenever services are required.

Most Covered Services are provided or arranged by the Member's Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services that the Member needs, a Referral to a Non-Participating Provider will be arranged by the Member's Primary Care Physician, with approval by the Claims Administrator. See ***Access to Primary, Specialist, And Hospital Care*** in the ***General Information*** section for procedures for obtaining Preapproval for use of a Non-Participating Provider.

Some Covered Services must be Preapproved before the Member can receive the services. The Primary Care Physician or Referred Specialist must seek the Claims Administrator's approval and confirm that coverage is provided for certain services. Preapproval of services is a vital program feature that reviews Medical Necessity of certain procedures and/or admissions. In certain cases, Preapproval helps determine whether a different treatment may be available that is equally effective yet less traumatic. Preapproval also helps determine the most appropriate setting for certain services.

If a Primary Care Physician or Referred Specialist provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment. To access a complete list of services that require Preapproval, log onto www.ibx.com/preapproval, or the Member can call Customer Service at the phone number listed on the Member's ID Card to have the list mailed to the Member.

If the Member should have questions about any information in this Benefit Booklet or need assistance at any time, please feel free to contact Customer Service by calling the telephone number shown on the Member's ID Card.

PRIMARY AND PREVENTIVE CARE

The Member is entitled to benefits and Primary and Preventive Care Covered Services when:

- The Member's Primary Care Physician (PCP) either provides or arranges for these Covered Services, as noted.
- The Member's Primary Care Physician (PCP) provides a Referral, when one is required, to a Participating Professional Provider when their condition requires a Specialist's Services.

If the Member receives services that result from a Referral to a Non-Participating Provider, the following will apply:

- They will be covered, when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Claims Administrator.

- The Referral will be valid for 90 days from the date it was issued. This is the case, so long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider, contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Claims Administrator about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:
- This will require yet another electronic referral from the Member's Primary Care Physician.

Self-Referrals are excluded, except for Emergency Services or if covered by a Rider. The only time the Member can self-refer is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

"**Preventive Care**" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Member has no symptoms of disease.

"**Primary Care**" services generally describe health care services performed to treat an illness or injury.

The Claims Administrator reviews the ***Schedule of Covered Services***, at certain times. Reviews are based on recommendations from organizations such as:
- The American Academy of Pediatrics;
- The American College of Physicians;
- The U.S. Preventive Services Task Force; and
- The American Cancer Society.

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

The Claims Administrator reserves the right to modify the Preventive Schedule document at any time.

Immunizations
The Claims Administrator will provide coverage for the following:
- Pediatric Immunizations;
- Adult Immunizations; and
- The agents used for the Immunizations.

All immunizations and the agents must conform to the standards of the *Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services*.

Pediatric and adult Immunization schedules may be found in the Preventive Schedule document.

Nutrition Counseling
The Claims Administrator will provide coverage for nutrition counseling visits or sessions. However, they need to be performed and billed by any of the following Providers, in an office setting:

- By the Member's Physician;
- By a Referred Specialist; or
- By a Registered Dietitian (RD).

This benefit is in addition to any other nutrition counseling Covered Services described in this Benefit Booklet. The Member does not need a Referral from their Primary Care Physician to obtain services for Nutrition Counseling.

A Referral from your Primary Care Physician is not required to obtain services for Nutrition Counseling.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)
The Claims Administrator will provide coverage for Bone Mineral Density Testing (BMDT) in accordance with the Preventive Schedule document. The method used needs to be one that is approved by the U.S. Food and Drug Administration. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which depends on both bone density and bone quality. Bone quality refers to how the bone is built, architecture, turnover and mineralization of bone.

The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

Preventive Care - Adult
Adult Preventive Care includes routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document attached to the Contract.

Preventive Care - Pediatric
Pediatric Preventive Care includes routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document attached to the Contract.

Primary Care Physician Office Visits/Retail Clinics
The Claims Administrator will provide coverage for Medical Care visits, by a Primary Care Physician, for any of the following services:

- The examination of an illness or injury;
- The diagnosis of an illness or injury;
- The treatment of an illness or injury;

For the purpose of this benefit, "Office Visits" include:

- Medical Care visits to a Primary Care Physician's office;
- Medical Care visits to the Member's residence;
- Medical Care consultations on an Outpatient basis;
- Medical Care visits to the Member's Primary Care Physician's office, during and after regular office hours; or
- Emergency visits and visits to the Member's residence, if within the Service Area.

In addition to Office Visits a Member may receive Medical Care at a Retail Clinic. Retail Clinics are staffed by certified family nurse practitioners, who are trained to diagnose, treat, and write Prescriptions when clinically appropriate. Nurse practitioners are supported by a local Physician who is on-call during clinic hours to provide guidance and direction when necessary.

Examples of treatment and services that are provided at a Retail Clinic include, but are not limited to:

- Sore throat;
- Ear, eye, or sinus infection;
- Allergies;
- Minor burns;
- Skin infections or rashes; and
- Pregnancy testing.

Smoking Cessation

Smoking cessation includes clinical preventive services rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) as described under the Preventive Services provision of the Patient Protection and Affordable Care Act.

Women's Preventive Care

Women's Preventive Care includes coverage for an initial physical examination for pregnant women to confirm pregnancy, screening for gestational diabetes, and other Covered Services, in accordance with the Preventive Schedule document.

Covered Services and Supplies include, but are not limited to, the following:

- Routine Gynecological Exam, Pap Smear. Members are covered for one (1) routine gynecological exam each Benefit Period. This includes the following:
  - A pelvic exam and clinical breast exam; and
  - Routine Pap smears.

  These must be done in accordance with the recommendations of the *American College of Obstetricians and Gynecologists.*

  Members have direct access to care by a participating obstetrician or gynecologist. This means the Member does not need a referral, from the Member's Primary Care Physician, to receive this care**.**
- Mammograms. Coverage will be provided for screening mammograms without Referral. The Claims Administrator will only provide benefits for mammography if the following applies:
  - It is performed by a qualified mammography service Provider.
  - It is performed by a Participating Provider who is properly certified by the appropriate state or federal agency.
  - That certification is done in accordance with the Mammography Quality Assurance Act of 1992.

- Breastfeeding comprehensive support and counseling from trained providers; access to breastfeeding supplies, including coverage for rental of hospital-grade breastfeeding pumps under DME with Medical Necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member when provided by a Participating Provider.
- Contraception: The Women's Preventive Services Initiative recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care. The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration (FDA) include
  - Sterilization surgery for women;
  - Surgical sterilization implant for women;
  - Implantable rod;
  - IUD copper;
  - IUD with progestin;
  - The shot or injection;
  - Oral contraceptives (combined pill);
  - Oral contraceptives (progestin only, and);
  - Oral contraceptives (extended or continuous use);
  - The contraceptive patch;
  - Vaginal contraceptive rings;
  - Diaphragm;
  - Contraceptive sponges;
  - Cervical caps;
  - Female condoms;
  - Spermicides;
  - Emergency contraception (levonorgestrel); and
  - Emergency contraception (ulipristal acetate).
- Although all Food and Drug Administration-approved contraceptive methods and patient education and counseling are covered, only certain contraceptive drug options in each category are covered at no cost share to the Member when provided by a Participating Provider. Contraception drugs and devices are covered under this Program unless otherwise covered under the Prescription Drug benefit issued with this Program. Abortifacients are not considered contraceptives.

If a Member's Physician determines that they require more than one well-women visit annually to obtain all recommended preventive services (based on the women's health status, health needs and other risk factors), the additional visit(s) will be provided without cost-sharing.

INPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Inpatient Care are Covered Services when they are:
- Deemed Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preapproved by the Claims Administrator.

If the Member receives services that result from a Referral to a Non-Participating Provider, the following will apply:

- They will be covered, when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Claims Administrator.
- The Referral will be valid for 90 days from the date it was issued. This is the case, so long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider, contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Claims Administrator about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:

- This will require yet another electronic referral from the Member's Primary Care Physician.

Self-Referrals are excluded, except for Emergency Services or if covered by a Rider. The only time the Member can self-refer is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

Hospital Services

- Ancillary Services
  The Claims Administrator will provide coverage for all ancillary services usually provided and billed for by Hospitals, except for personal convenience items. This includes, but is not limited to:
  - Meals, including special meals or dietary services, as required by the Member's condition;
  - Use of operating room, delivery room, recovery room, or other specialty service rooms and any equipment or supplies in those rooms;
  - Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
  - Oxygen and oxygen therapy;
  - Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
  - Therapy Services when administered by a person who is appropriately licensed and authorized to perform such services;
  - All drugs and medications (including intravenous injections and solutions);
    - For use while in the Hospital;
    - Which are released for general use; and
    - Which are commercially available to Hospitals.

    (The Claims Administrator reserves the right to apply quantity level limits as conveyed by the FDA or the Claims Administrator's Pharmacy and Therapeutics Committee for certain Prescription Drugs.)
  - Use of special care units, including, but not limited to intensive care units or coronary care units; and
  - Pre-admission testing.

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

Medical Care
The Claims Administrator will provide coverage for Medical Care rendered to the Member, in the following way, except as specifically provided.

It is Medical Care that is rendered:
- By a Participating Professional Provider who is in charge of the case;
- While the Member is an Inpatient in a Participating Facility Provider that is a Hospital, Rehabilitation Hospital or Skilled Nursing Facility; and
- For a condition not related to Surgery, pregnancy, or Mental Illness.

Such care includes Inpatient intensive Medical Care rendered to the Member:
- While the Member's condition requires a Referred Specialist constant attendance and treatment; and
- For a prolonged period of time.

- Concurrent Care
  The Claims Administrator will provide coverage for the following services, while the Member is an Inpatient when they occur together:
  - Services rendered to the Member by a Referred Specialist:
    - Who is not in charge of the case; but
    - Whose particular skills are required for the treatment of complicated conditions.
  - Services rendered to the Member in a Participating Facility Provider as an Inpatient in a:
    - Hospital;
    - Rehabilitation Hospital; or
    - Skilled Nursing Facility.

  This does not include:
  - Observation or reassurance of the Member;
  - Standby services;
  - Routine preoperative physical examinations;
  - Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods; or
  - Medical Care required by a Participating Facility Provider's rules and regulations.

- Consultations
  The Claims Administrator will provide coverage for Consultation services when rendered in a Participating Facility Provider in both of the following ways:
  - By a Referred Specialist, at the request of the attending Participating Professional Provider; and
  - While the Member is an Inpatient in a:
    - Hospital;
    - Rehabilitation Hospital; or
    - Skilled Nursing Facility.

  Consultations do not include staff consultations which are required by the Participating Facility Provider's rules and regulations.

Skilled Nursing Facility
The Claims Administrator will provide coverage for a Participating Skilled Nursing Facility:
- When Medically Necessary as determined by this Claims Administrator.
- When the Member requires treatment by skilled nursing personnel which can be provided:
  - Only on an Inpatient basis; and
  - Only in a Skilled Nursing Facility.
- As long as the services are not considered Custodial or Domiciliary Care. Benefits are limited to semi-private accommodations (or an allowance equal to this rate which may be applied to private accommodations).

During the Member's admission, members of the Claims Administrator's Care Management and Coordination team are monitoring the Member's stay.

They do this to:
- Assure that a plan for the Member's discharge is in place; and
- Make sure that the Member has a smooth transition from the facility to home or other setting.
- A case manager will work closely with the Member's Primary Care Physician, or the Referred Specialist to help with the Member's discharge. If necessary, they will arrange for other medical services, as well.

Should the Member's Primary Care Physician, or Referred Specialist, agree with the Claims Administrator that continued stay in a Skilled Nursing Facility is no longer required:
- The Member will be notified in writing of this decision.
- Should the Member decide to remain in the facility after its notification, the facility has the right to bill the Member after the date of the notification.
- The Member may appeal this decision through the Medical Necessity Appeal process.

INPATIENT/OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Inpatient or Outpatient Care are Covered Services when they are:
- Deemed Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preapproved by the Claims Administrator.

If the Member receives services that result from a Referral to a Non-Participating Provider:

- They will be covered when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Claims Administrator.
- The Referral is valid for 90 days from the date it was issued. This is the case, as long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Claims Administrator about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:

- This will require yet another electronic referral from your Primary Care Physician.

Self-Referrals are excluded, except for Emergency Services or if covered by a Rider. The only time the Member can self-refer is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

Blood

The Claims Administrator will provide coverage for the administration of blood and blood processing from donors. In addition, benefits are also provided for:

- Autologous blood drawing, storage or transfusion.
  - This refers to a process that allows the Member to have their own blood drawn and stored for personal use.
  - One example would be self-donation, in advance of planned Surgery.
- Whole blood, blood plasma and blood derivatives:
  - Which are not classified as Prescription Drugs in the official formularies; and
  - Which have not been replaced by a donor.

Hospice Services

The Claims Administrator will provide coverage for palliative and supportive services to a terminally ill Member through a Hospice program by a Participating Hospice Provider.

- Who is eligible: The Member will be eligible for Hospice benefits if both of the following occur:
  - The Member's attending Primary Care Physician or Referred Specialist certifies that the Member has a terminal illness, with a medical prognosis of six months or less
  - The Member elects to receive care primarily to relieve pain.
- The goal of care and what is included: Hospice Care provides services to make the Member as comfortable and pain-free as possible. This is primarily comfort care, and it includes:
  - Pain relief;
  - Physical care;
  - Counseling; and
  - Other services, that would help the Member cope with a terminal illness, rather than cure it.
- What happens to the treatment of the Member's illness: When the Member elects to receive Hospice Care:
  - Benefits for treatment provided to cure the terminal illness are no longer provided.
  - The Member can also change their mind and elect to not receive Hospice Care anymore.

- How long Hospice care continues: Benefits for Covered Hospice Services shall be provided until whichever occurs first:
  - The Member's discharge from Hospice Care; or
  - The Member's death.
- Respite Care for the Caregiver: If the Member were to receive Hospice Care primarily in the home, the Member's primary caregiver may need to be relieved, for a short period. In such a case, the Claims Administrator will provide coverage for the Member to receive the same kind of care in the following way:
  - On a short-term basis;
  - As an Inpatient; and
  - In a Medicare certified Skilled Nursing Facility.

This can only be arranged when the Hospice considers such care necessary to relieve primary caregivers in the Member's home.

Maternity/OB-GYN/Family Services

- Artificial Insemination
  Facility services provided by a Participating Facility Provider and services performed by a Referred Specialist for the promotion of fertilization of a recipient's own ova (eggs):
  - By the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying:
    - Simple sperm preparation;
    - Sperm washing; and/or
    - Thawing.

- Elective Abortions
  The Claims Administrator will provide coverage for services provided in a Participating Facility Provider that is a Hospital or Birth Center. It also includes services performed by a Referred Specialist for the voluntary termination of a pregnancy by a Member.

- Maternity/Obstetrical Care
  The Claims Administrator will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.
  - Pre-notification **-** The Claims Administrator should be notified of the need for maternity care within one month of the first prenatal visit to the Physician or Certified Midwife.
  - Facility and Professional Services **-** The Claims Administrator will provide coverage:
    - Facility services: Provided by Participating Facility Provider that is a Hospital or Birth Center; and
    - Professional services: Performed by a Referred Specialist or Certified Midwife;
    - The Claims Administrator will provide coverage for certain services provided by a Referred Specialist for elective home births.
  - Scope of Care **-** The Claims Administrator will provide coverage for:
    - Prenatal care;
    - Postnatal care; and
    - Complications of pregnancy and childbirth.
  - Type of delivery **-** Maternity care Inpatient benefits will be provided for:
    - 48 hours for vaginal deliveries; and
    - 96 hours for cesarean deliveries.

Except as otherwise approved by the Health Benefit Plan.

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

- Newborn Care
  - A Member's newborn child will be entitled to benefits provided by this Program:
    - From the date of birth up to a maximum of 31 days
  - Such coverage within the 31 days will include care which is necessary for the treatment of:
    - Medically diagnosed congenital defects;
    - Medically diagnosed birth abnormalities;
    - Medically diagnosed prematurity; and
    - Routine nursery care.
  - Coverage for a newborn may be continued beyond 31 days under conditions specified in the ***General Information*** section of this Benefit Booklet.

Mental Health Care and Serious Mental Illness Health Care

The Claims Administrator will provide coverage for the treatment of Mental Health Care and Serious Mental Illness Health Care based on the services provided and reported by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

- Regarding a non-mental health provider who renders non-mental health care: When a Participating Professional Provider other than a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider, renders Medical Care to the Member other than Mental Health Care or Serious Mental Illness Health Care:
  - Coverage for such Medical Care will be based on the medical benefits available as shown in the ***Schedule of Covered Services*** included with this Benefit Booklet.
- A Referral from the Member's Primary Care Physician is not required to obtain Inpatient or Outpatient Mental Health Care or Serious Mental Illness Health Care. Instead:
  - Contact the Member's Primary Care Physician; or
  - Call the Mental Health phone number shown on the Member's ID card.
- Inpatient Mental Health Care and Serious Mental Illness Health Care: Benefits are provided for Covered Services during an Inpatient Mental Health Care or Serious Mental Illness Health Care admission for the treatment of a Mental Illness, including a Serious Mental Illness provided by a Participating Behavioral Health/Alcohol or Drug Abuse and Dependency. Inpatient Care Covered Services include treatments such as:
  - Psychiatric visits;
  - Psychiatric consultations;
  - Individual and group psychotherapy;
  - Electroconvulsive therapy;
  - Psychological testing; and
  - Psychopharmacologic management
- Outpatient Mental Health Care and Serious Mental Illness Health Care: The Claims Administrator will provide coverage for Covered Services during an Outpatient Mental Health Care or Serious Mental Illness Health Care visit for:
  - The treatment of a Mental Illness, including a Serious Mental Illness; and
  - Provided by a Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

Outpatient Care Covered Services include treatments such as:

- Psychiatric visits;
- Psychiatric consultations;
- Individual and group psychotherapy;
- Participating Licensed Clinical Social Worker visits;
- Masters Prepared Therapist visits;
- Electroconvulsive therapy;
- Psychological testing;
- Psychopharmacologic management, and psychoanalysis; and
- Telebehavioral Health Services

All Intensive Outpatient Program and Partial Hospitalization services must be approved by the Claims Administrator.

The criteria for Medical Necessity determinations made by the Participating Behavioral Health/Substance Abuse Provider with respect to Mental Health and Serious Mental Illness Health Care benefits will be made available to the Member upon request.

Routine Patient Costs Associated With Qualifying Clinical Trials

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

Surgical Services

The Claims Administrator will provide coverage for surgical services provided:

- By a Participating Professional Provider, and/or a Participating Facility Provider;
- For the treatment of disease or injury.

Separate payment will not be made for:

- Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure.

Covered Services also include:

- Congenital Cleft Palate. The orthodontic treatment of congenital cleft palates:
  - That involve the maxillary arch (the part of the upper jaw that holds the teeth);
  - That is performed together with bone graft Surgery; and
  - That is performed to correct bony deficits that are present with extremely wide clefts affecting the alveolus.

- Mastectomy Care. The Claims Administrator will provide coverage for the following when performed after a mastectomy:
  - 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 and physical complications all stages of mastectomy, including lymphedemas; and
- Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to:
  - Augmentation;
  - Mammoplasty;
  - Reduction mammoplasty; and
  - Mastopexy.

Coverage is also provided for:

- The surgical procedure performed in connection with the initial and subsequent insertion or removal of Prosthetic Devices (either before or after Surgery) to replace the removed breast or portions of it; and
- The treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedemas is not subject to any benefit Maximum amounts that may apply to "Physical Therapy" services as provided under the subsection entitled "Therapy Services" of this section.

- Routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

- Anesthesia
  The Claims Administrator will provide coverage for the administration of Anesthesia:
  - In connection with the performance of Covered Services; and
  - When rendered by or under the direct supervision of a Referred Specialist other than the surgeon, assistant surgeon or attending Referred Specialist.

  General Anesthesia, along with hospitalization and all related medical expenses normally incurred as a result of the administration of general Anesthesia, when rendered in conjunction with dental care provided to Members age seven (7) or under and for developmentally disabled Members when determined by the Health Benefit Plan to be Medically Necessary and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.

- Assistant at Surgery
  The Claims Administrator will provide coverage for an assistant surgeon's services if:
  - The assistant surgeon actively assists the operating surgeon in the performance of covered Surgery;
  - An intern, resident, or house staff member is not available; and
  - The Member's condition or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Claims Administrator.

- Hospital Admission for Dental Procedures or Dental Surgery.
  The Claims Administrator will provide coverage for a Hospital admission in connection with dental procedures or Surgery only when:
  - The Member has an existing non-dental physical disorder or condition; and
  - Hospitalization is Medically Necessary to ensure the Member's health.

  Dental procedures or Surgery performed during such a confinement will only be covered for the services described in "Oral Surgery" and "Assistant at Surgery" provisions.

- Oral Surgery
  The Claims Administrator will provide coverage for oral Surgery which is subject to special conditions as described below:
  - Orthognathic Surgery – Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:
    - For accidents: The initial treatment of Accidental Injury/trauma (That is, fractured facial bones and fractured jaws), in order to restore proper function.
    - For congenital defects**:** In cases where it is documented that a severe congenital defect (That is, cleft palate) results in speech difficulties that have not responded to non-surgical interventions.
    - For chewing and breathing problems: In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic Surgery will decrease airway resistance, improve breathing, or restore swallowing.
  - Other Oral Surgery – Defined as Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered Service will only be provided for:
    - Surgical removal of impacted teeth which are partially or completely covered by bone;
    - Surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
    - Surgical removal of teeth prior to cardiac Surgery, Radiation Therapy or organ transplantation.

  To the extent that the Member has available dental coverage, the Claims Administrator reserves the right to seek recovery from the Provider.

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

- Second Surgical Opinion (Voluntary)
  The Claims Administrator will provide coverage for consultations for Surgery to determine the Medical Necessity of an elective surgical procedure.
  - "Elective Surgery" is that Surgery which is not of an Emergency or life threatening nature.
  - Such Covered Services must be performed and billed by a Referred Specialist other than the one who initially recommended performing the Surgery.

Transplant Services
Transplant Services benefits are provided at Facility Providers designated by the Blue Cross and Blue Shield Association as a Blue Distinction Center and Blue Distinction+ Center. The Claims Administrator will provide a list of Facility Providers designated as a Blue Distinction Center and Blue Distinction+ Center. When the Blue Distinction Center or Blue Distinction+ Center facility is more than 100 miles from the Member's residence, certain travel & lodging

expenses for the Member and one companion may be reimbursed if pre-authorized by the Claims Administrator. Travel is reimbursed between the Member's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. To be eligible for travel & lodging reimbursement, the Member (or Provider) must pre-authorize evaluation and treatment, the Member must utilize a Blue Distinction Center or Blue Distinction+ Center facility and obtain preauthorization for travel and lodging. If it is determined by the Claims Administrator that the Transplant Services cannot be performed at a Blue Distinction Center or Blue Distinction+ Center, the Covered Person may obtain the Covered Services at a Participating Facility Provider that is not designated as a Blue Distinction Center or Blue Distinction+ Center. No benefits are payable for Transplant Services provided at a Non-Participating Provider.

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 Claims Administrator, 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.

Treatment for Alcohol Or Drug Abuse And Dependency

- Alcohol Or Drug Abuse And Dependency is a disease that can be described as follows: It is an addiction to alcohol and/or drugs. It is also the compulsive behavior that results from this addiction.
  - This addiction makes it hard for a person to function well with other people.
  - It makes it hard for a person to function well in the work that they do.
  - It will also cause person's body and mind to become quite ill if the alcohol and/or drugs are taken away.
- The Claims Administrator will provide coverage for the care and treatment of Alcohol Or Drug Abuse And Dependency based on the services provided and reported by the Participating Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.
- A Referral from the Member's Primary Care Physician is not required to obtain Inpatient or Outpatient Alcohol Or Drug Abuse And Dependency treatment.
- To Access Treatment for Alcohol Or Drug Abuse And Dependency:
  - Contact the Member's Primary Care Physician; or
  - Call the behavioral health management company at the phone number shown on the Member's ID Card.

- <u>Inpatient Treatment</u>
  - Covered Services include:
    - The diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency, including Detoxification;
    - At a Participating Facility Provider that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

  Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling, during an Inpatient Alcohol Or Drug Abuse And Dependency treatment admission in an Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

  Covered Services include:
  - Lodging and dietary services;
  - Diagnostic services, including psychiatric, psychological and medical laboratory tests;
  - Services provided by a staff Physician, a Psychologist, a registered or Licensed Practical Nurse, and/or a certified addictions counselor;
  - Rehabilitation therapy and counseling;
  - Family counseling and intervention; and

- Prescription Drugs, medicines, supplies and use of equipment provided by the Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

- Outpatient Treatment
  - Covered Services include:
    - The diagnosis and medical treatment of Alcohol Or Drug Abuse And Dependency, including Detoxification;
    - At a Participating Facility Provider that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.

  Benefits are also provided for Covered Services for non-medical treatment, such as vocational rehabilitation or employment counseling, during an Outpatient Alcohol Or Drug Abuse And Dependency treatment admission in an Alcohol Or Drug Abuse And Dependency Treatment Facility or a Residential Treatment Facility that is a Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider.
  Covered Services include:
  - Diagnostic services, including psychiatric, psychological and medical laboratory tests;
  - Services provided by the Behavioral Health/Alcohol And Drug Abuse Or Dependency Provider on staff;
  - Telebehavioral Health services;
  - Rehabilitation therapy and counseling;
  - Family counseling and intervention; and
  - Medication management and use of equipment and supplies provided by the Alcohol And Drug Abuse Or Dependency or a Residential Treatment Facility that is a Behavioral Health/ Alcohol And Drug Abuse Or Dependency Provider.

The criteria for Medical Necessity determinations made by the Participating Behavioral Health/ Alcohol Or Drug Abuse And Dependency Provider with respect to Treatment for Alcohol Or Drug Abuse And Dependency benefits will be made available to the Member upon request.

OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, Services for Outpatient Care are Covered Services when:
- Deemed Medically Necessary;
- Provided or Referred by the Member's Primary Care Physician; and
- Preapproved by the Claims Administrator.

If the Member receives services that result from a Referral to a Non-Participating Provider, the following will apply:
- They will be covered, when the Referral is issued by the Member's Primary Care Physician and Preapproved by the Claims Administrator.
- The Referral will be valid for 90 days from the date it was issued. This is the case, so long as the Member is still enrolled in this Program.
- If the Member receives any bills from the Provider, contact Customer Service at the telephone number found on the Member's ID card. When the Member notifies the Claims Administrator about these bills, it will resolve the balance billing.

If the Referred Specialist recommends additional Covered Services:

- This will require yet another electronic referral from the Member's Primary Care Physician.

Self-Referrals are excluded, except for Emergency Services or if covered by a Rider. The only time the Member can self-refer is for Emergency Services.

Note: Cost-sharing requirements, if any, are specified in the ***Schedule of Covered Services***.

Acupuncture
The Health Benefit Plan will provide coverage for Acupuncture up to the limits specified in the *Schedule of Covered Services* for all Covered Services**.**

Ambulance Services/Transport
The Claims Administrator will provide coverage for Emergency ambulance services. However, these services need to be:

- Medically Necessary as determined by the Claims Administrator; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when all the following applies;
  - The vehicle is licensed as an ambulance, where required by applicable law;
  - The ambulance transport is appropriate for the Member's clinical condition;
  - The use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would endanger the Member's health or be inappropriate for the Member's medical condition; and,
  - The ambulance transport satisfies the destination and other requirements as stated under Regarding Emergency Ambulance transport or Regarding Non-Emergency Ambulance transports provisions below.

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

Benefits are payable for air or sea ambulance transportation only if the Member's condition, and the distance to the nearest facility able to treat the Member's condition, justify the use of an alternative to land transport.

- Regarding Emergency Ambulance transport: The ambulance must be transporting the Member:
  - From the Member's home, or the scene of an accident or Medical Emergency;
  - To the nearest Hospital, or other Emergency Care Facility, that can provide the Medically Necessary Covered Services for the Member's condition.

- Regarding Non-Emergency Ambulance transport:
  - Non-emergency air or ground facility to facility transport may be covered when Medically Necessary as determined by the Claims Administrator (e.g. sending facility does not have the required services to effectively treat the Member, such as trauma or burn care).

- Non-emergency air or ground transport may be covered to transport the Member back to a Participating Facility Provider in the Member's Service Area as determined by the Claims Administrator, when:
  - The transfer is Medically Necessary (as determined by the Claims Administrator's definition of Medical Necessity); and
  - The Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance.
  - Non-emergency ambulance transports are not provided for family members or companions, or for the convenience of the Member, the family, or the Provider treating the Member.

Autism Spectrum Disorders (ASD)

The Claims Administrator will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for the Members when provided by the Primary Care Physician for the development of an ASD Treatment Plan. Treatment of Autism Spectrum Disorders must be:

- Prescribed, ordered or provided by a Participating Professional Provider, including the Member's Primary Care Physician, Referred Specialist, licensed Physician Assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner;
- Provided by an Autism Service Provider, including a Behavior Specialist;
- Provided by a person, entity or group that works under the direction of an Autism Service Provider; or
- Provided through a school as part of an individualized education program.

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

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

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

  If this Program does not provide coverage for Outpatient Prescription Drugs through this Program or under a Freestanding Prescription Drug agreement issued by an affiliate of Keystone***,*** ASD medications may be purchased at a retail pharmacy, and are covered at the cost sharing stated in the Member's ***Schedule of Covered Services***. In order to

receive reimbursement, the Member must submit a completed claim form to the address listed on the form. The Member can access a claim form at the Claims Administrator's website or the Member can call Customer Service at the phone number listed on the ID Card to have one mailed to them.

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

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

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

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

Upon full or partial denial of coverage for any Autism Spectrum Disorders benefits, a Member shall be entitled to file an appeal. The appeal process will:

- Provide internal review followed by independent external review; and,
- Have levels, expedited and standard appeal time frames, and other terms established by the Health Benefit Plan consistent with applicable Pennsylvania and federal law.

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

Colorectal Cancer Screening
The Claims Administrator will provide coverage for colorectal cancer screening for Symptomatic Members, Nonsymptomatic Members over age 50, and Nonsymptomatic Members under age 50 who are at high risk or increased risk for colorectal cancer. Coverage for colorectal cancer screening must be in accordance with the current American Cancer Society guidelines, and consistent with approved medical standards and practices. Benefits are provided for the following Covered Services:

- Coverage for Symptomatic Members shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a Primary Care Physician or Referred Specialist Provider.
- Coverage for Nonsymptomatic Members over age 50 shall include:
  - An annual fecal occult blood test;
  - A sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years; and
  - A colonoscopy at least once every ten years.
- Coverage for Nonsymptomatic Members under age 50 who are at high or increased risk for colorectal cancer shall include a colonoscopy or any combination of colorectal cancer screening tests.

"Nonsymptomatic Member at high or increased risk" means a Member who poses a higher than average risk for colorectal cancer according to the current American Cancer Society guidelines on screening for colorectal cancer.

"Symptomatic Member" means a Member who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

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

Day Rehabilitation Program
The Claims Administrator will provide coverage for a Medically Necessary Day Rehabilitation Program when provided by a Participating Facility Provider under the following conditions:
- Intensity of need for therapy: The Member must require intensive Therapy Services, such as Physical, Occupational and/or Speech Therapy five days per week;
- Ability to communicate: The Member must have the ability to communicate (verbally or non-verbally); their needs; they must also have the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff;
- Willingness to participate: The Member must be willing to participate in a Day Rehabilitation Program; and
- Family support: The Member's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

Limitations: This benefit is subject to the limits shown in the ***Schedule of Covered Services***.

Diabetic Education Program
When prescribed by a Participating Professional Provider legally authorized to prescribe such items under law**,** the Claims Administrator will provide coverage for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of:

- Insulin-dependent diabetes;
- Insulin-using diabetes;
- Gestational diabetes; and
- Noninsulin-using diabetes.

A Referral from the Member's Primary Care Physician is not required to obtain services for the Diabetic Education Program benefits.

When Physician certification must occur: The attending Physician must certify that a Member requires diabetic education on an Outpatient basis, under the following circumstances:

- Upon the initial diagnosis of diabetes;
- Upon a significant change in the Member's symptoms or condition; or
- Upon the introduction of new medication or a therapeutic process in the treatment or management of the Member's symptoms or condition.

Requirements that must be met: Outpatient diabetic education services will be covered when they meet specific requirements**.**

- These requirements are based on the certification programs for Outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.
- Specific requirements: Outpatient diabetic education services and education program must:
  - Be provided by a Participating Provider
  - Be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Claims Administrator.

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

- Initial assessment of the Member's needs;
- Family involvement and/or social support;
- Psychological adjustment for the Member;
- General facts/overview on diabetes;
- Nutrition including its impact on blood glucose levels;
- Exercise and activity;
- Medications;
- Monitoring and use of the monitoring results;
- Prevention and treatment of complications for chronic diabetes, (That is, foot, skin and eye care);
- Use of community resources; and
- Pregnancy and gestational diabetes, if applicable.

Diabetic Equipment and Supplies

- Coverage and costs: The Claims Administrator will provide coverage for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. This is subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits.

When diabetic equipment and supplies can be purchased at a pharmacy:

- If this Program provides benefits for Prescription Drugs (other than coverage for insulin and oral agents only):
  - Certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, if available.
  - This will be subject to the cost-sharing arrangements, applicable to the Prescription Drug coverage.

When diabetic equipment and supplies are not available at a pharmacy:

- The diabetic equipment and supplies will be provided under the Durable Medical Equipment benefit.
- This will be subject to the cost-sharing arrangements applicable to Durable Medical Equipment.

- Covered Diabetic Equipment:
  - Blood glucose monitors;
  - Insulin pumps;
  - Insulin infusion devices; and
  - Orthotics and podiatric appliances for the prevention of complications associated with diabetes.
- Covered Diabetic Supplies:
  - Blood testing strips;
  - Visual reading and urine test strips;
  - Insulin and insulin analogs*;
  - Injection aids;
  - Insulin syringes;
  - Lancets and lancet devices;
  - Monitor supplies;
  - Pharmacological agents for controlling blood sugar levels*; and
  - Glucagon emergency kits.

* **Note:** If this Program does not provide coverage for Prescription Drugs, insulin and oral agents are covered as provided under the "Insulin and Oral Agents" benefits.

Diagnostic Services

The Claims Administrator will provide coverage for the following Diagnostic Services, when ordered by a Participating Professional Provider; and billed by a Referred Specialist, and/or a Participating Facility Provider:

- Routine Diagnostic Services, such as:
  - Routine radiology: Consisting of x-rays, mammograms, ultrasound, and nuclear medicine;
  - Routine medical procedures: Consisting of ECG, EEG, and other diagnostic medical procedures approved by the Claims Administrator; and
  - Allergy testing: Consisting of percutaneous, intracutaneous and patch tests.
- Non-Routine Diagnostic Services, such as:
  - Nuclear Cardiology Imaging;
  - MRI/MRA;
  - CT Scans;
  - PET Scans; and
  - Sleep Studies.

- Genetic testing and counseling.
  This includes services provided to a Member at risk for a specific disease that is a result of:
  - Family history; or
  - Exposure to environmental factors that are known to cause physical or mental disorders.

  When clinical usefulness of specific genetic tests has been established by the Claims Administrator, these services are covered for the purpose of:
  - Diagnosis;
  - Screening;
  - Predicting the course of a disease;
  - Judging the response to a therapy;
  - Examining risk for a disease; or
  - Reproductive decision-making

Durable Medical Equipment

The Claims Administrator will provide coverage for the rental (but not to exceed the total allowance) or, at the option of the Claims Administrator, the purchase of Durable Medical Equipment when:

- It is used in the Member 's home; and
- It is obtained through a Participating Durable Medical Equipment Provider.

Replacement and Repair

The Claims Administrator will provide coverage for the repair or replacement of Durable Medical Equipment when the equipment:

- Does not function properly; and
- Is no longer useful for its intended purpose, in the following limited situations:
  - Due to a change in a Member's condition: When a change in the Member's condition requires a change in the Durable Medical Equipment the Claims Administrator will provide repair or replacement of the Equipment;
  - Due to breakage: When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Claims Administrator will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Claims Administrator.

  Breakage under warranty: If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of:
  - The Claims Administrator in the case of rented equipment; and
  - The Member, in the case of purchased equipment.

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

Cost to repair vs. cost to replace: The Claims Administrator will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment:

- Replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning.
- A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage or defect.

Gender Dysphoria and Sexual Reassignment Therapy

The Claims Administrator provides coverage for treatment of gender dysphoria including coverage for psychotherapy visits and hormone replacement therapy for all Members and Dependents. The Claims Administrator also provides coverage for surgical procedures to treat gender dysphoria for Members and Dependents where the services are prescribed by a licensed treating Provider acting within their scope of practice (in such cases, these services are treated as Medically Necessary), including:

- Genital reconstruction for male to female gender reassignment and female to male gender reassignment;
- Transmasculine and transfeminine top surgery;
- Facial reshaping; and
- Laryngeal shaving.

The Claims Administrator covers additional services to treat gender dysphoria when determined to be Medically Necessary for Members and Dependents.

Home Health Care

- Covered Services: The Claims Administrator will provide coverage for the following services when performed by a licensed Home Health Care Provider:
  - Professional services of appropriately licensed and certified individuals;
  - Intermittent Skilled Nursing Care;
  - Physical Therapy;
  - Speech Therapy;
  - Well mother/well baby care following release from an Inpatient maternity stay; and
  - Care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy.
- Regarding well mother/well baby care: With respect to well mother/well baby care following early release from an Inpatient maternity stay, Home Health Care services must be provided within 48 hours if:
  - Discharge occurs earlier than 48 hours of a vaginal delivery; or
  - Discharge occurs earlier than 96 hours of a cesarean delivery.

  No cost sharing shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.
- Regarding other medical services and supplies: Benefits are also provided for certain other medical services and supplies, when provided along with a primary service. Such other services and supplies include:
  - Occupational Therapy;
  - Medical social services; and
  - Home health aides in conjunction with skilled services and other services which may be approved by the Claims Administrator.

- Regarding Medical Necessity: Home Health Care benefits will be provided only when prescribed by the Member's attending Physician, in a written Plan Of Treatment and approved by the Claims Administrator as Medically Necessary.
- Regarding the issue of being confined: There is no requirement that the Member be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.
- Regarding being Homebound: With the exception of Home Health Care provided to a Member, immediately following an Inpatient release for maternity care, the Member must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

Injectable Medications
The Claims Administrator will provide coverage for injectable medications required in the treatment of an injury or illness when administered by a Participating Professional Provider.

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

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

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

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

    - If the drug is covered under the Injectable Medication benefit of this Benefit Booklet and is administered by a healthcare Provider in a Hospital Outpatient facility, provider's office, ambulatory (or free-standing) infusion suite, home (through a

home infusion vendor), inpatient Hospital, or any other health care facility, this drug is eligible for coverage under the medical benefit:
  - Injectable medications are subject to the cost-share specified in the Schedule of Covered Services.

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

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

- Standard Injectable Drugs
  - Refers to a medication that is either injectable or infusible, but is not defined by the Health Benefit Plan to be a Self-Administered Prescription Drug or a Specialty Drug.
  - These include, but are not limited to:
    - Allergy injections and extractions; and
    - Injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.

- Self-Administered Prescription Drugs
  - Are generally not covered except as covered under a Prescription Drug benefit.
    - For more information on Self-Administered Prescription Drugs please refer to the ***Exclusions*** – ***What Is Not Covered*** section and the description of "Insulin and Oral Agents" coverage in the ***Description of Covered Services*** section.

Insulin and Oral Agents
The Claims Administrator will provide coverage for insulin and oral agents to control blood sugar when Prescribed by the Member's Primary Care Physician or Referred Specialist. Generically equivalent pharmaceuticals will be dispensed whenever applicable.

Laboratory and Pathology Tests

Medical Foods and Nutritional Formulas
- The Claims Administrator 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 will provide coverage for Nutritional Formulas when the Nutritional Formula is administered through a tube.

- The Health Benefit Plan will provide coverage for oral elemental formulas for an infant or child suffering from Severe Systemic Protein Allergy, food protein-induced enterocolitis syndrome, eosinophilic disorders, or short-bowel syndrome that do not respond to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

- The Claims Administrator will provide coverage for Medical Foods and Nutritional Formulas when provided through a Participating Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this 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.

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

Non-Surgical Dental Services
The Claims Administrator will provide coverage only for**:**
- The initial treatment of Accidental Injury/trauma, (That is, fractured facial bones and fractured jaws), in order to restore proper function.

  Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, required for the initial treatment for the Accidental Injury/trauma. This includes:
  - The first caps;
  - Crowns;
  - Bridges; and
  - Dentures (but not dental implants).
- The preparation of the jaws and gums required for initial replacement of Sound Natural Teeth.

Orthotics (Devices Used for Support of Bones and Joints)
The Claims Administrator will provide coverage for:
- The first purchase and fitting: This is the initial purchase and fitting (per medical episode) of orthotic devices which are Medically Necessary as determined by the Claims Administrator. This does not include foot orthotics, unless the Member requires foot orthotics as a result of diabetes.
- Replacements due to growth: The replacement of covered orthotics for Dependent children when required due to natural growth.

Note: Foot orthotics, ordered and covered as a result of diabetes, must be purchased through a Participating Durable Medical Equipment Provider.

Podiatric Care
Benefits are provided for podiatric care including: capsular or surgical treatment of bunions; ingrown toenail surgery; and other non-routine Medically Necessary foot care. In addition, for Members with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, benefits for routine foot care services are provided.

Private Duty Nursing Services
The Claims Administrator will provide coverage for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by the Member's Primary Care Physician or a Referred Specialist as a part of a home health care treatment plan and which are Medically Necessary.

Prosthetic Devices
The Claims Administrator will provide coverage for Prosthetic Devices required as a result of illness or injury. Benefits include but are not limited to:

- The purchase and fitting, and the necessary adjustments and repairs, of Prosthetic Devices and supplies (except dental prostheses);
- Supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device, except coverage is not available for enhancements or deluxe supplies or convenience features that do not serve or contribute towards any clinically established physiological and/or functional improvements;
- Visual Prosthetics when Medically Necessary and Prescribed for one of the following conditions:
  - Initial contact lenses Prescribed for the treatment of infantile glaucoma;
  - Initial pinhole glasses Prescribed for use after Surgery for detached retina;
  - Initial corneal or scleral lenses Prescribed in connection with the treatment of keratoconus or to reduce a corneal irregularity (other than astigmatism);
  - Initial scleral lenses Prescribed to retain moisture in cases where normal tearing is not present or adequate; and
  - An initial pair of basic eyeglasses when Prescribed to perform the function of a human lens lost (aphakia) as a result of Accidental Injury, Trauma, or Ocular Surgery.

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

The Claims Administrator will provide coverage for the replacement of a previously approved Prosthetic Device with an equivalent Prosthetic Device when:

- There is a significant change in the Member's condition that requires a replacement;
- The Prosthetic Device breaks because it is defective;
- The Prosthetic Device breaks because it has exceeded its life duration as determined by the manufacturer; or
- The Prosthetic Device needs to be replaced for a Dependent child due to the normal growth process when Medically Necessary.

The Claims Administrator will provide coverage for the repair of a Prosthetic Device when the cost to repair is less than the cost to replace it. Repair means the restoration of the Prosthetic Device or one of its components to correct problems due to wear or damage. Replacement means the removal and substitution of the Prosthetic Device or one of its components necessary for proper functioning.

If an item breaks and is under warranty, it is the Member's responsibility to work with the manufacturer to replace or repair it.

The Claims Administrator will neither replace nor repair the Prosthetic Device due to abuse or loss of the item.

Specialist Office Visits
The Claims Administrator will provide coverage for Specialist Services Medical Care provided in the office by a Referred Specialist other than a Primary Care Provider.

For the purpose of this benefit "in the office" includes:
- Medical Care visits to a Provider's office;
- Medical Care visits by a Provider to the Member's residence; or
- Medical Care consultations by a Provider on an Outpatient basis.

Spinal Manipulation Services
The Claims Administrator will provide coverage for the detection and correction of structural imbalance or dislocation (subluxation) of the Member's spine resulting from, or related to any of the following:
- Distortion of, or in, the vertebral column;
- Misalignment of, or in, the vertebral column; or
- Dislocation (Subluxation) of, or in, the vertebral column.

The detection and correction can be done by manual or mechanical means (by hand or machine).

This service will be provided for, up to the limits specified in the ***Schedule of Covered Services*** for spinal manipulations.

Therapy Services
The Claims Administrator will provide coverage for the following forms of therapy:
- Cardiac Rehabilitation Therapy
  Refers to a medically supervised rehabilitation program designed to improve a Member's tolerance for physical activity or exercise.

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

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

- Dialysis
  Dialysis treatment when provided in the Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in the home. In the case of home Dialysis, Covered Services will include equipment, training, and medical supplies. Private Duty Nursing is not covered as a portion of Dialysis. The decision to provide Covered Services for the purchase or rental of necessary equipment for home Dialysis will be made by the Claims Administrator. The Covered Services performed in a Participating Facility Provider or by a Participating Professional Provider for Dialysis are available without a Referral.

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

- Occupational Therapy
  Coverage will also include services rendered by a registered, licensed occupational therapist. The Member is required to have these services performed by the Member's Primary Care Physician's Designated Provider.

- Orthoptic/Pleoptic Therapy
  The Claims Administrator will provide coverage for treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye Surgery, or injury resulting in the lack of vision depth perception.

- Physical Therapy
  Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio- mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part. The Member is required to have these services performed by the Member's Primary Care Physician's Designated Provider.

- Pulmonary Rehabilitation Therapy
  Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

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

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

Travel and Lodging
The Claims Administrator will provide coverage for eligible travel and lodging expenses for Medical Care that is unavailable to be performed by an In-Network Provider within 100 miles of the Member's home address; or through virtual care. The travel and lodging benefit as defined by the Claims Administrator covers eligible expenses for the treatment of all Covered Expenses under this Program up to the Maximums specified in the ***Schedule of Covered Services***. Services provided and travel/lodging benefits must comply with all applicable laws, including being legally permissible in the state where they are obtained.

- Travel allowances:
  - Travel is reimbursed between the Member's home and the treatment facility for round trip (air, train, bus, rideshare) transportation costs. Airfare must be for a regularly scheduled commercial flight (economy/coach class ticket only; one bag per Member, one bag for companion for each flight). If traveling by car to the treatment facility, mileage, parking, and toll costs are eligible for reimbursement. Mileage reimbursement will be based on the current Internal Revenue Service (IRS) medical mileage reimbursement. Please refer to the IRS website, www.irs.gov, for current rates; and
  - Reimbursement of eligible expenses Incurred by a Member and companion for lodging at a hotel/motel while away from home is set at the Maximums specified in the ***Schedule of Covered Services***;
- Companion: Coverage is provided if the companion's presence is necessary for the Member to receive services. Benefits are limited to one companion;
- Limits:
  - The Program covers travel and lodging costs up to the IRS limits in place on the date the expense is Incurred. The per day limits and requirements can change if IRS regulations change. Please refer to the IRS website, www.irs.gov, for details. This summary is not and should not be assumed to be, tax advice;
- Members are required to fill out and file the 'Medical Travel Claim Form' and submit to the Claims Administrator; and

There is no Member cost-sharing associated with this travel and lodging benefit. However, the satisfaction of any applicable Deductible is required.

Urgent Care Centers
The Claims Administrator will provide coverage for Urgent Care Centers, when Medically Necessary as determined by the Claims Administrator.

- Urgent Care Centers are designed to offer immediate evaluation and treatment for health conditions that require medical attention:
  - In a non-Emergency situation;
  - That cannot wait to be addressed by the Member's Participating Professional Provider or Retail Clinic.

Cost-sharing requirements are specified in the ***Schedule of Covered Services***.

Virtual Care Services
Services Provided by Contracted Vendor:
Virtual care services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone, secure video, when a Professional Provider is unavailable or inaccessible. These licensed providers do not replace an existing Professional Provider relationship but enhances it with an efficient,

convenient alternative for non-emergency medical problems. The applicable vendor provider cost-sharing requirements are specified in the Schedule of Covered Services. The Member will pay the applicable cost-sharing via credit or debit card prior to the consultation.

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

Vision Care (Medical)
Vision screening to determine the need for refraction when performed by the Member's Primary Care Physician.

EMERGENCY AND URGENT CARE

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

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

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

Emergency Services Inside and Outside the Service Area.
Emergency Services are covered whether they are provided inside or outside Keystone's Service Area. Emergency Services do not require a Referral for treatment from the Member's Primary Care Physician.

The Member must notify their Primary Care Physician to coordinate all continuing care.

Medically Necessary Care by any Provider other than the Member's Primary Care Physician will be covered until the Member can, without medically harmful consequences, be transferred to the care of the Member's Primary Care Physician or a Referred Specialist.

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

Note: For Emergency Care provided by certain Non-Participating Providers, for example, ambulance services, in accordance with applicable law, the Claims Administrator will reimburse the Non-Participating Provider based upon the methodology established by Consolidated Appropriations Act (CAA).

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

It is the Member's responsibility to contact the Claims Administrator for any bill the Member receives for out-of- area Urgent Care provided by a Non-Participating Provider. If the Member receives any bills from the Provider, the Member needs to contact Customer Service at the telephone number on the Member's ID card. When the Member notifies the Claims Administrator about these bills, the Claims Administrator will resolve the balance billing.

MEDICAL SCREENING EVALUATION
Medical Screening Evaluation services will be Covered Services when performed in a Hospital emergency department for the purpose of determining whether or not an Emergency exists.

NOTE: If the Member believes they need Emergency Services, the Member should call 911 or go immediately to the emergency department of the closest Hospital. Coverage of reasonably necessary costs associated with Emergency Services provided during the period of the Emergency are covered by this Program.

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

Urgent Care Inside Keystone's Service Area

If the Member is within the Service Area and they need Urgent Care, they call their Primary Care Physician first. The Member's Primary Care Physician provides coverage 24 hours a day, seven days a week for Urgent Care. The Member's Primary Care Physician, or the Physician covering for their Primary Care Physician, will arrange for appropriate treatment. Urgent Care services may also be accessed directly at an Urgent Care Center or Retail Clinic.

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

WHAT IS FOLLOW-UP CARE?
"Follow-Up Care" is Medically Necessary follow-up visits that occur while the Member is outside the Health Benefit Plan's Service Area. Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is in the Health

Benefit Plan's Service Area. An example is Dialysis. Follow-Up Care must be Preapproved by the Member's Primary Care Physician prior to traveling. This service is available for temporary absences (less than 90 consecutive days) from the Health Benefit Plan's Service Area.

ACCESS TO COVERED SERVICES OUTSIDE KEYSTONE'S SERVICE AREA

Members have access to health care services when traveling outside of Keystone's service area. The length of time that the Member will be outside the Service Area will determine whether benefits will be available through the BlueCard Program or the Away From Home Care Guest Membership Program.

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

THE BLUECARD®PROGRAM

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

Urgent Care required during a temporary absence will be covered when:

- The Member calls 1-800-810-BLUE. This number is available 24 hours a day, seven days a week.
- The Member will be given the names, addresses and phone numbers of three BlueCard Providers. The BlueCard Program has some international locations. When the Member calls, the Member will be asked whether the Member is inside or outside of the United States.
- The Member decides which Provider the Member will visit.
- The Member calls 1-800-ASK-BLUE to get prior authorization for the service from Keystone.
- With Keystone's approval, the Member calls the Provider to schedule an appointment. The BlueCard Provider confirms Member eligibility.
- The Member shows their ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of the Member's visit.

Follow-Up Care Benefits under the BlueCard Program

Follow-Up Care Benefits under the BlueCard Program cover Medically Necessary Follow-Up Care required while the Member is traveling outside of Keystone's Service Area. The care must be needed for urgent ongoing treatment of an injury, illness, or condition that occurred while the Member was in Keystone's Service Area. Follow- Up Care must be pre-arranged and Preapproved by the Member's Primary Care Physician and the health plan in Keystone's Service Area prior to leaving the Service Area. Under the BlueCard Program, coverage is provided only for the specified, Preapproved service(s) authorized by the Member's Primary Care Physician in Keystone's Service Area and Keystone's Care

Management and Coordination Department. Follow-Up Care Benefits under the BlueCard Program are available during the Member's temporary absence (less than 90 consecutive days) from Keystone's Service Area.

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

- The Member is currently receiving urgent ongoing treatment for a condition.
- The Member plans to go out of Keystone's Service Area temporarily, and the Member's Primary Care Physician recommends that the Member continues treatment.
- The Member's Primary Care Physician must call 1-800-ASK-BLUE to get prior authorization for the service from Keystone. If a BlueCard Provider has not been pre-selected for the Follow-Up Care, the Member's Primary Care Physician or the Member will be told to call 1-800-810-BLUE.
- The Member or the Member's Primary Care Physician will be given the names, addresses and phone numbers of three BlueCard Providers.
- Upon deciding which BlueCard Provider will be visited, the Member or the Member's Primary Care Physician must inform Keystone by calling the number on the ID Card.
- The Member should call the BlueCard Provider to schedule an appointment.
- The BlueCard Provider confirms the Member's eligibility.
- The Member shows the Member's ID Card when seeking services from the BlueCard Provider.
- The Member pays the Copayment at the time of the Member's visit.

THE AWAY FROM HOME CARE®PROGRAM

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

Who is Eligible to Register for Guest Membership Benefits?

The Member may register for Guest Membership Benefits when:

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

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

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

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

NOTE: Because the Member's Primary Care Physician in the Keystone's Service Area can give advice and provide recommendations about health care services that the Member may need while traveling, the Member is encouraged to receive routine or planned care prior to leaving home.

As a Guest Member, the Member must select a Primary Care Physician from the Host HMO's Primary Care Physician network. In order to receive Guest Membership Benefits, the Primary Care Physician in the Host HMO Service Area must provide or arrange for all of the Member's Covered Services while the Member is a Guest Member. Neither Keystone nor the Host HMO will cover services the Member receives as a Guest Member that are not provided or arranged by the Primary Care Physician in the Host HMO Service Area and Preapproved by the Host HMO. Registration in the Away From Home Care Program is available only through contracting HMOs in the Blue Cross and Blue Shield Association's HMO network. Information regarding the availability of Guest Membership Benefits may be obtained from the Away From Home Care Coordinator by calling Customer Service at the telephone number shown on the ID Card.

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

Renewal of Guest Membership

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

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

The Member must call Customer Service at the telephone number on the back of their ID Card, each time the Guest Member moves in or out of the Keystone Service Area so that the HMO may ensure proper assignment of the Primary Care Physician to enable access to care for the Guest Member.

The Member must notify the HMO whenever the following happens:
– The Guest Member comes home for break or a short period of time; or
– The Guest Member returns to the Host Service Area.

WHEN THE MEMBER DOESN'T USE THE BLUECARD OR GUEST MEMBERSHIP PROGRAMS

If the Member has out-of-area Urgent Care or Emergency Services, not provided as described above and provided by a Non-Participating Provider, ask the Provider to submit the bill to Keystone. Show the Provider the Member ID Card for necessary information about the Member's Group plan. For direct billing, the Provider should mail the bill to the address in the next sentence. If direct billing cannot be arranged, send us a letter explaining the reason care was needed and an original itemized bill to:

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

NOTE: It is the Member's responsibility to forward to Keystone any bill the Member receives for Emergency Services or out-of-area Urgent Care provided by a Non-Participating Provider.

CONTINUING CARE

Medically Necessary care provided by any Provider other than the Member's Primary Care Physician will be covered, subject to the ***Description Of Covered Services, Exclusions - What Is Not Covered***, and the ***Schedule Of Covered Services*** sections, only until the Member can, without medically harmful consequences, be transferred to the care of the Member's Primary Care Physician or a Referred Specialist designated by the Member's Primary Care Physician.

All continuing care must be provided or Referred by the Member's Primary Care Physician or coordinated through Customer Service.

AUTO OR WORK-RELATED ACCIDENTS

Motor Vehicle Accident

If the Member or the Member's Dependent is injured in a motor vehicle accident, contact the Member's or the Member's Dependent's Primary Care Physician as soon as possible.

REMEMBER: This Program will always be secondary to the Member's auto insurance coverage. However, in order for services to be covered by this Program as secondary, the Member's care must be provided or Referred by the Member's Primary Care Physician.

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

Call Customer Service as soon as possible and advise us that the Member has been involved in a motor vehicle accident. This information helps the Claims Administrator to coordinate this Program's benefits with coverage provided through the Member's auto insurance company.

Only services provided or Referred by the Member's Primary Care Physician will be covered by this Program.

Work-Related Accident
Report any work-related injury to the Member's employer and contact the Member's Primary Care Physician as soon as possible.

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

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

Call Customer Service as soon as possible and advise us that the Member has been involved in a work-related accident. This information helps the Claims Administrator to coordinate this Program's benefits with coverage provided through the Member's employer's Worker's Compensation coverage.

Only services provided or Referred by the Member's Primary Care Physician will be covered by this Program.

EXCLUSIONS – WHAT IS NOT COVERED

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

Administration of Insulin
Any charges for the administration of injectable insulin.

Alternative Therapies/Complementary Medicine
For Alternative Therapies/complementary medicine, including but not limited to:

- Music therapy;
- Dance therapy;
- Equestrian/hippotherapy;
- Homeopathy;
- Primal therapy;
- Rolfing;
- Psychodrama;
- Vitamin or other dietary supplements and therapy;
- Naturopathy;
- Hypnotherapy;
- Bioenergetic therapy;
- Gi Gong;
- Ayurvedic therapy;
- Aromatherapy;
- Massage therapy;
- Therapeutic touch;
- Recreational, wilderness, educational and sleep therapies.

Ambulance Services/Transport
For Ambulance services/transport except as specifically provided under this Program.

Artificial Insemination

Assisted Fertilization Techniques
For In vitro fertilization, embryo transplant, ovum retrieval including, but not limited to, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and any services required in connection with these procedures.

Autism

- For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

Benefit Maximums
For charges Incurred for expenses in excess of benefit maximums as specified in the ***Schedule of Covered Services***.

Charges In Excess Of Covered Service For Insulin
Any charge where the usual and customary charge is less than the Member's Insulin or oral agent cost sharing amount.

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

Consumable Medical Supplies
With regard to Consumable Medical Supplies, any item that meets the following criteria is not a covered consumable medical supply and will not be covered:

- The item is for comfort or convenience.
- The item is not primarily medical in nature. Items not covered include, but are not limited to: ear plugs; ice pack; silverware/utensils; feeding chairs; toilet seats
- The item has features of a medical nature which are not required by the patient's condition.
- The item is generally not prescribed by an eligible provider.

Some examples of not covered consumable medical supplies are: incontinence pads; lamb's wool pads; face masks (surgical); disposable gloves, sheets and bags, bandages, antiseptics, and skin preparations.

Correctional Facility

- While a Member is incarcerated in any adult or juvenile penal or correctional facility or institution; or
- Care for conditions that federal, state or local law requires to be treated in a public facility.

Cosmetic Surgery

- For cosmetic Surgery, including cosmetic dental Surgery.
- Cosmetic Surgery is defined as any Surgery:
  - Done primarily to alter or improve the appearance of any portion of the body; and
  - From which no significant improvement in physiological function could be reasonably expected.

Regarding sagging skin: This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to:

- The eyelids;
- Face;
- Neck;
- Arms;
- Abdomen;
- Legs; or
- Buttocks.

Regarding enlargements, reductions and implantations: This exclusion also includes services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including, but not limited to:

- The ears;
- Lips;
- Chin; or
- Jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

Regarding bodily functions and deformities: This exclusion does not include those services performed when the patient is a Member of the Program and performed in order to restore bodily function or correct deformity resulting from:

- A disease;
- Recent trauma; or
- Previous therapeutic process.

Regarding birth defects: This exclusion does not apply to otherwise Covered Services necessary to correct:

- Medically diagnosed congenital defects for children and birth abnormalities for children.

Dental Care (Medical)

- For dental services related to:
  - The care, filling, removal or replacement of teeth, including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta; and
  - The treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this Benefit Booklet.
  - Specific services not covered include, but are not limited to (unless otherwise described in this Benefit Booklet):
    - Apicoectomy (dental root resection);
    - Prophylaxis of any kind;
    - Root canal treatments;
    - Soft tissue impactions;
    - Alveolectomy;
    - Bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and
    - Treatment of periodontal disease;
- For dental implants for any reason.
- For dentures, unless for the initial treatment of an Accidental Injury/trauma.
- For Orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.
- For injury as a result of chewing or biting (neither is considered an Accidental Injury).

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

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

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

- **Delandistrogene moxeparvovec**

- **Tofersen**

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

- **Lecanemab-irmb (Leqembi)**

Drugs That May Be Dispensed Without A Doctor's Prescription

For drugs and other medications:

- Outpatient Prescription Drugs, except if covered by the Prescription Drug benefit; and,
- Medications that may be dispensed without a doctor's prescription.

This exclusion does not apply for coverage of insulin and oral agents used for the treatment of diabetes or for Prescription Drugs used in the treatment of Autism Spectrum Disorders, when the Member does not have coverage through a Prescription Drug benefit.

Durable Medical Equipment

With respect to Durable Medical Equipment (DME), items for which any of the following statements are true is not DME, and will not be covered. This includes any item:

- That is for comfort or convenience: Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps, and telephone alert systems; bed-wetting alarms; and, ramps.
- That is for environmental control: Items not covered include, but are not limited to: air cleaners; air conditioners; dehumidifiers; portable room heaters; customized wheelchairs and ambient heating and cooling equipment.
- That is inappropriate for home use: This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes.
- That is a non-reusable supply or is not a rental type item, other than a supply that is an integral part of the DME item required for the DME function. This means the equipment is not durable or is not a component of the DME.
- That is not primarily medical in nature: Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered medical equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to:
  - Exercise equipment;
  - Speech teaching machines;
  - Strollers;
  - Toileting systems;
  - Bathtub lifts;
  - Elevators;
  - Stair glides; and
  - Electronically-controlled heating and cooling units for pain relief
- That has features of a medical nature which are not required by the patient's condition, such as a gait trainer: The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists: A Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.
- That duplicates or supplements existing equipment for use when traveling or for an additional residence: For example: A patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would NOT be eligible for two identical items, or one for each living space.
- Which is not customarily billed for by the Provider. Items not covered include, but are not limited to: delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.
- That modifies vehicles, dwellings, and other structures: This includes any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability; or to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
- Equipment for safety: Items that are not primarily used for the diagnosis, care or treatment of disease or injury but are primarily utilized to prevent injury or provide a safe surrounding. Examples include:
  - Restraints;
  - Safety straps;
  - Safety enclosures; or
  - Car seats.

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

Effective Date
Which were Incurred prior to the Member's Effective Date of coverage.

Experimental/Investigative
Services and supplies which are Experimental/Investigative in nature, except:
- Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Benefit Booklet; and
- As Preapproved by the Claims Administrator.

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

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

Foot Orthotics
For supportive devices for the foot (orthotics), such as, but not limited to:
- Foot inserts;
- Arch supports;
- Heel pads and heel cups; and
- Orthopedic/corrective shoes.

This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes.

Health foods and Dietary Supplements
For health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents.

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

High Cost Technical Equipment
For equipment costs related to services performed on high cost technological equipment unless the acquisition of such equipment was approved through a Certificate of Need process and/or the Claims Administrator.

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.

Home Health Care
For Home Health Care services and supplies in connection with Home health services for the following:

- Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
- Rental or purchase of Durable Medical Equipment;
- Rental or purchase of medical appliances (For example, braces) and Prosthetic Devices (For example, artificial limbs); supportive environmental materials and equipment, such as:
  - Handrails;
  - Ramps;
  - Telephones;
  - Air conditioners and similar services;
  - Appliances; and
  - Devices;
- Prescription Drugs;
- Provided by family members, relatives, and friends;
- A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
- Emergency or non-Emergency Ambulance services;
- Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
- Visits by any Provider personnel solely for the purpose of assessing a Member's condition and determining whether or not the Member requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

Hospice Care
Hospice Care benefits for the following:

- Research studies directed to life lengthening methods of treatment;
- Services or expenses Incurred in regard to the Member's personal, legal and financial affairs (such as preparation and execution of a will or other disposition of personal and real property); and
- Private Duty Nursing.

Immediate Family
Rendered by a member of the Member's Immediate Family.

Immunizations for Employment or Travel
Immunizations required for employment purposes or travel.

Intensive Behavioral Health Services/Pediatric Intensive Behavioral Health Services
For services designated as intensive behavioral health services/pediatric intensive behavioral health services (defined in Pennsylvania Medical Assistance Manual Chapter 1155), except as specifically provided under this Program (For example, Applied Behavior Analysis).

Laboratory and Pathology Tests for Employment
For laboratory and pathology tests in connection with obtaining or continuing employment.

Lipedema
Liposuction (suction-assisted lipectomy) for the treatment of lipedema.

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

Medical Foods And Nutritional Formulas
- For appetite suppressants; and
- For oral non-elemental nutritional supplements (For example, Boost, Ensure, NeoSure, PediaSure, Scandishake), 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" subsection in the ***Description of Covered Services*** section.
- For elemental semi-solid foods (e.g. Neocate Nutra)
- For products that replace fluids and electrolytes (e.g., Electrolyte Gastro, Pedialyte)
- For oral additives (e.g., Duocal, fiber, probiotics, or vitamins) and food thickeners (e.g., Thick-It, Resource ThickenUp)
- For supplies associated with the oral administration of formula (e.g., bottles, nipples)

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

Medical Necessity or Referred

- Not provided by or Referred by the Member's Primary Care Physician except in an Emergency or as specified elsewhere in this Benefit Booklet; and

- Which are not Medically Necessary, as determined by the Primary Care Physician or the Claims Administrator, for the diagnosis or treatment of illness, injury or restoration of physiological functions. This exclusion does not apply to routine and preventive Covered Services specifically provided under the Claims Administrator and described in this Benefit Booklet.

Military Service
For any loss sustained or expenses Incurred in the following ways:
- During military service while on active duty as a member of the armed forces of any nation; or
- As a result of enemy action or act of war, whether declared or undeclared.

Miscellaneous

- For care in a:
  - Long term care facility, including a:
    - Nursing home;
    - Assisted living facility; and
    - Board and care home;
  - Continuing care retirement facility
  - Convalescent home;
  - School, with the exception of behavioral health services specified in the HMO's Medical Policies;
  - Camp, with the exception of behavioral health services specified in the HMO's Medical Policies; or
  - Institution for intellectually disabled children
- For broken appointments;
- For marriage or religious counseling;
- For completion of any insurance forms.
- For Custodial Care, or domiciliary care;
- For charges not billed/performed by a Provider.
- For services for which the cost is later recovered through legal action, compromise, or claim settlement;
- For protective and supportive care, including educational services, rest cures and convalescent care.
- Performed by a Professional Provider enrolled in an education or training program when such services are:
  - Related to the education or training program; and are
  - Provided through a Hospital or university.
- For weight reduction and premarital blood tests. This exclusion does not apply to nutrition visits as set forth in the ***Description of Covered Services*** section under the subsection entitled "Nutrition Counseling"***.***
- For any Therapy service provided for:
  - Work hardening activities/programs;
  - Evaluations not associated with therapy.

Motor Vehicle Accident

For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is:

- Paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan; or
- Payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.

Non-Covered Services

For any services, supplies or treatments not specifically listed as covered benefits in this Program.

Note: The Claims Administrator reserves the right:

- To specify Providers of, or means of delivery of Covered Services, supplies or treatments under this Program; and
- To substitute such Providers or sources where medically appropriate.

EXCEPTIONS - No benefits are provided for the above, unless:
The unlisted benefit, service or supply is a basic health service required by the Pennsylvania Department of Health.

Obesity
For treatment of obesity including pharmacological drugs for the treatment of obesity management. This includes, but not limited: (a) weight management programs; (b) dietary aids, supplements; (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 Claims Administrator:
  - 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 complications 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" provision in this Benefit Booklet.

Organ Donation
Services required by a Member donor related to organ donation. Expenses for donors donating organs to Member recipients are covered only as provided in this Program and described in this Benefit Booklet. No payment will be made for human organs which are sold rather than donated.

Personal Hygiene and Convenience Items
For personal hygiene and convenience items such as, but not limited to the following, whether or not recommended by a Provider:

- Air conditioners;
- Humidifiers;
- Physical fitness or exercise equipment;
- Radio;
- Beauty/barber shop services;
- Guest trays;
- Chairlifts;
- Stairglides;
- Elevators;
- Spa or health club memberships;
- Whirlpool;
- Sauna;
- Television;
- Telephone;
- Guest service; or
- Hot tub or equivalent device

Physical Examinations
For routine physical examinations for non-preventive purposes, such as:
- Pre-marital examinations;
- Physicals for college, camp or travel; and
- Examinations for insurance, licensing and employment.

Prescription Drugs (Medical Program)
- For Prescription Drugs, except as may be provided by a Prescription Drug Rider attached to this Benefit Booklet.
- For drugs and medicines for which the Member has coverage under a free-standing prescription drug program provided through the enrolled Group.
- For Prescription Drugs, except for insulin, insulin analogs and pharmacological agents for controlling blood sugar levels, as provided for the treatment of diabetes and for contraceptives as mandated by the Women's Preventive Services provision of PPACA, including contraceptive methods as described in the Women's Preventive Care provision of the **Description of Covered Services** section of this Benefit Booklet, patient education and counseling, not including abortifacient drugs, and for certain generic and brand products. All other contraceptives are excluded.

Private Duty Nursing
- For Private Duty Nursing Services in connection with the following:
  - Nursing care which is primarily custodial in nature; such as care that primarily consists of bathing, feeding, exercising, homemaking, moving the patient and giving oral medication;
  - Services provided by a nurse who ordinarily resides in the Member's home or is a member of the Member's Immediate Family; and
  - Services provided by a home health aide or a nurse's aide.
- For Inpatient Private Duty Nursing services.

Prosthetic Device Repair and Replacement Due to Misuse
For services for repairs or replacements of Prosthetic Devices needed because the prosthesis was abused or misplaced.

Relative Counseling or Consultations
For counseling or consultation with a Member's relatives, or Hospital charges for a Member's relatives or guests, except as may be specifically provided or allowed in the "Treatment for Alcohol Or Drug Abuse And Dependency" or "Transplant Services" subsections of the ***Description of Covered Service*s** section.

Responsibility of Another Party
- For which a Member would have no legal obligation to pay, or another party has primary responsibility.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

Responsibility of Medicare
Claims paid or payable by Medicare when Medicare is primary. For purposes of this Program exclusion, coverage is not available for a service, supply or charge that is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premium for, maintains, claims or receives

Medicare benefits. The amount excluded for these claims will be either the amount "payable under Medicare" or the applicable plan fee schedule for the service, at the discretion of the Health Benefit Plan **or** Claims Administrator, as applicable.

Reversal of a Sterilization
For any Surgery performed for the reversal of a sterilization and services required in connection with such procedures.

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

This exclusion does not apply to Self- Administered Prescription Drugs that are:
- Mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by a Prescription Drug benefit or free-standing prescription drug contract issued by the Health Benefit Plan or its affiliates; or
- Required for treatment of an Emergency condition that requires a Self- Administered Prescription Drug.

Services Not Performed By a Designated Provider
The following Outpatient services that are not performed by the Member's Primary Care Physician's Designated Provider, when required under the plan:
- Rehabilitation Therapy Services: (other than Speech Therapy and services for Autism Spectrum Disorders);
- Diagnostic radiology services: If the Member is age five (5) or older; and
- Laboratory and Pathology Tests.

EXCEPTIONS - No benefits are provided for the above, unless Preapproved by the Claims Administrator.

Services with No Charge
Medication furnished by any other medical service for which no charge is made to the Member.

Sexual Dysfunction
Sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist.

Skilled Nursing Facility
For Skilled Nursing Facility services in connection with the following:
- When confinement is intended solely to assist the Member with the activities of daily living or to provide an institutional environment for the convenience of a Member;
- For the treatment of Alcohol And Drug Abuse Or Dependency, and Mental Illness; or
- After the Member has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care.

Temporomandibular Joint Syndrome (TMJ)
For oral devices used for the treatment of temporomandibular joint syndrome (TMJ) or dysfunction.

Termination Date
Which were or are Incurred after the date of termination of the Member's coverage except as provided in the ***General Information*** section.

Transplant Services
For Outpatient Transplant Services.

Travel and Lodging
For the following travel and lodging expenses (based on IRS guidelines), including, but not limited to:

- Alcohol/tobacco;
- Animal kennel fees;
- Automobile rental;
- Automobile depreciation, insurance, general repair or maintenance expenses;
- Childcare expenses;
- Entertainment (For example, movies, visits to museums, additional mileage for sightseeing, etc.);
- Expenses for persons other than the Member and their covered companion;
- Internet connection;
- Laundry/dry cleaning;
- Lost wages;
- Meals;
- Pet or animal expenses, other than service animals;
- Personal care items (For example, shampoo, deodorant, toothbrush, etc.);
- Security deposits;
- Souvenirs;
- Telephone calls/facsimile (fax);
- Taxes;
- Tips/gratuities; and
- Shipping services (For example, Fedex, UPS, USPS, etc.).

Veteran's Administration or Department of Defense
To the extent a Member is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Member.

Vision Care (Medical)
Vision care, including but not limited to:

- All surgical procedures performed solely to eliminate the need for or reduce the Prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty;
- Lenses which do not require a Prescription;
- Any lens customization such as, but not limited to tinting, oversize or progressive lenses; antireflective coatings, U-V lenses or coatings, scratch resistant coatings, mirror coatings, or polarization;
- Deluxe frames; or
- Eyeglass accessories such as cases, cleaning solution and equipment.
- For eyeglasses, lenses or contact lenses and the vision examination for Prescribing or fitting eyeglasses; or
- Routine Vision exams except as otherwise described in this Benefit Booklet.

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

This exclusion also applies to pharmacological drugs for weight reduction.

This exclusion does not apply to the Claims Administrator's weight reduction program nutrition counseling visits/sessions as described in the "Nutrition Counseling" provision in this Benefit Booklet.

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

Worker's Compensation
For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of:
- Worker's Compensation Law; or
- Any similar Occupational Disease Law or Act.

This exclusion applies whether or not the Member claims the benefits or compensation.

GENERAL INFORMATION

ELIGIBILITY, CHANGE AND TERMINATION RULES UNDER THIS PROGRAM

The Member's Group benefits administrator is responsible for maintaining eligibility of Members to receive benefits under this Program and for timely notifying the Claims Administrator of such eligibility. The Claims Administrator will provide coverage, and terminate coverage, in reliance on the Group's timely notification of the eligibility of Members. If a Group fails to timely notify the Claims Administrator of the eligibility status of a particular Member, the will provide and terminate coverage in accordance with any Claims Administrator administrative processes.

ELIGIBILITY

Eligible Subscriber

An eligible Subscriber is an individual who is listed on the completed Enrollment/Change Form provided by the Claims Administrator and:

- Who resides or, with approval from the Claims Administrator, works in the Service Area; and
- Who is an Employee whose normal work week is defined by the Group or is an eligible retiree; and
- Who is entitled to participate in the Group's health benefits program, including compliance with any probationary or waiting period established by the Group or who is entitled to coverage under a trust agreement or employment contract; and
- For whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling.

Eligible Dependent

An eligible Dependent is an individual for whom Medicare is not primary pursuant to any federal or state regulation, law, or ruling; who resides in the Service Area, unless otherwise provided in this section; who meets all the eligibility requirements established by the Group; who is listed on the Enrollment/Change Form completed by the Subscriber; and who is:

- The Subscriber's legal spouse, if applicable; or

- A child (including stepchild, legally adopted child, child placed for adoption, or natural child) of either the Subscriber or the Subscriber's spouse, who is within the Limiting Age for Dependents as set forth in this Program, or a child for whom the Subscriber is legally required to provide health care coverage; or

- A child for whom the Subscriber or the Subscriber's spouse is a court appointed legal guardian; or

- A child, regardless of age, who, in the judgment of the Claims Administrator, is incapable of self-support due to a mental or physical handicap which commenced prior to the child's reaching the Limiting Age for Dependents under this Program and for which continuing justification may be required by the Claims Administrator; or

- A child within the Limiting Age for Dependents under this Program who resides in the Service Area; or

- A child who is past the Limiting Age for Dependents will be eligible when they:
  - Are a full-time student;
  - Are eligible for coverage under this Program;
  - Prior to attaining the Limiting Age for Dependents and while a full-time student, were:
    - A member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and were called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or,
    - A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

  Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

  As proof of eligibility, the Subscriber must submit a form to the Claims Administrator approved by the Department of Military & Veterans Affairs (DMVA):
  - Notifying the Claims Administrator that the Dependent has been placed on active duty;
  - Notifying the Claims Administrator that the Dependent is no longer on active duty; and
  - Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after their release from active duty.

- A child who is within the Limiting Age for Dependents as set forth in this Benefit Booklet, and who is a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from the Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The Limiting Age for Dependents will be applicable regardless of the status of the Medically Necessary leave of absence.

- A Dependent of a Subscriber who is enrolled in an HMO Medicare risk program. A Dependent child of such Subscriber must be within the Limiting Age for Dependents under this Program:

- The newborn child or adopted child of a Member for the first 31 days immediately following birth of the newborn or adopted child. Coverage will continue in effect thereafter if the newborn child or adopted child qualifies as a Dependent, is enrolled by the Subscriber within 31 days of birth, and any appropriate payment due, calculated from the 32nd day after birth, is received by the Claims Administrator; or

- A Domestic Partner, as long as the Domestic Partnership exists, the child or children of a Domestic Partner shall be considered for eligibility under the Program as if they were the Member's own child or children. If the Member enrolls their Domestic Partner, the Member has an affirmative obligation to notify the Claims Administrator immediately if the Domestic Partnership terminates. Upon termination of the Domestic Partner relationship, coverage of the former Domestic Partner and the children of the former Domestic Partner shall terminate at the end of the current monthly term.

The former Domestic Partner, and any of their previously covered children, shall be entitled, by applying within 60 days of such termination, to conversion coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This conversion coverage may be different from the coverage provided under this Benefit Booklet.

Under this Program no other benefits, except conversion privileges, will be extended to the newborn child of a Dependent unless such newborn child meets the eligibility requirements of a Dependent set forth in this section and is enrolled as a Dependent within 31 days of eligibility.

EFFECTIVE DATE OF COVERAGE

Subject to the receipt of applicable payments from the Group, and of an Enrollment/Change Form from or on behalf of each prospective Member, and subject to the provisions of this Program, coverage for Members under this Program shall become effective on the earliest of the following dates:

- When an eligible person makes written application for membership on or prior to the date on which eligibility requirements under this section are satisfied, coverage shall be effective as of the date the eligibility requirements are satisfied; or
- When an eligible person makes written application for membership after the date on which the eligibility requirements of this section are satisfied, but within 30 days after becoming eligible, coverage will be effective as of the date the eligibility requirements are satisfied; or
- Coverage shall become effective at birth for newborn children or adopted children for 31 days. Coverage will continue in effect thereafter if the newborn child or adopted child qualifies as a Dependent, is enrolled by the Subscriber within 31 days of birth, and any appropriate payment, calculated from the 32nd day after birth, is received by the Claims Administrator; or
- When an eligible person makes written application for membership during the Group Open Enrollment Period, coverage will begin on the first day of the calendar month following the conclusion of the Group Open Enrollment Period, unless otherwise agreed to by the Group and the Claims Administrator.

If on the date on which coverage under the Program becomes effective, the Member is receiving Inpatient Care, benefits will be provided under this Program to the extent that such benefits are not provided under a prior group health insurance plan.

WHEN TO NOTIFY THE PROGRAM OF A CHANGE

Certain changes in a Member's life may affect their coverage under this Program. Please notify us of any changes through the benefits office of the Member's Benefits Administrator. To help the Claims Administrator effectively administer Members' health care benefits, the Claims Administrator should be notified of the following changes within 30 days: name; address; status or number of Dependents; marital status; eligibility for Medicare coverage, or any other changes in eligibility.

Open Enrollment

The Member's Benefits Administrator will have an open enrollment period at least once a year, and will notify the Member of the time. At this time, the Member may add eligible Dependents to their coverage.

Newly Hired
Within 30 days of becoming eligible for this new Group coverage, an individual may join this Program. The Member must add existing eligible Dependents to their coverage at this time or wait until the next open enrollment period.

Late Enrollment
If an individual or an individual's Dependent did not request enrollment for coverage with this Program during the initial enrollment period and did not enroll within 30 days of the date during which the individual was first eligible to enroll under this Program, the individual may apply for coverage as a late Subscriber.

Marriage
Members may add their spouse to their Program within 30 days of their marriage. Coverage for a Member's spouse will be effective on the date of their marriage.

New Child
Coverage is effective at the time of birth for the newborn child of a Member, or at the time of placement for adoption for an adopted child of a Member, and shall continue for a period of 31 days after the event. If a Member chooses to continue coverage for the new child, the Member must add their eligible child (newborn or adopted child) within 31 days of the date of birth or placement of the adopted child. Coverage will be effective from the date of birth or the day the child was placed for adoption.

Customer Service must be notified prior to hospitalization for delivery.

Court-Ordered Dependent Coverage
If a Member is required by a court order to provide health care coverage for their eligible Dependent, their Dependent will be enrolled within 30 days from the date the Claims Administrator receives notification and a copy of the court order.

REMEMBER: The Member must notify the Claims Administrator of any changes to Dependent coverage within 30 days of the change in order to ensure coverage for all eligible family members. Notifications to the Claims Administrator should be through the benefits office of their Group benefits administrator.

TERMINATION OF COVERAGE
A Member's coverage may be cancelled, after receiving thirty (30) days advance written notice before cancellation and subject to their rights under the ***Appeal of an Administrative Denial and Medical Necessity Appeal Processes,*** under the following conditions:

- **Rescission:** If the Member commits intentional misrepresentation of a material fact or fraud in applying for or obtaining coverage from this Program. The Member will receive written notice at least thirty (30) days prior to termination but will have the right to utilize the ***Appeal of an Administrative Denial and Medical Necessity Appeal Processes*** to appeal cancellation;

- **Misuse of ID Card:** If a Member misuses their ID Card, or allows someone other than their eligible Dependents to use a ID Card to receive care or benefits;

- **Changes to Eligibility:** If a Member ceases to meet the eligibility requirements;

- **Group Termination:** The Member's Group terminates coverage with this Program.

Inpatient Provision upon Termination of Coverage
If a Member is receiving Inpatient Care in a Hospital or Skilled Nursing Facility on the day this coverage is terminated by the Claims Administrator, except for termination due to fraud or intentional misrepresentation of a material fact, the benefits shall be provided until the earliest of:
- The expiration of such benefits according to the ***Schedule of Covered Services*** included with this Benefit Booklet;
- Determination of the Primary Care Physician and the Claims Administrator that Inpatient Care is no longer Medically Necessary; or
- The Member's discharge from the facility.

NOTE: The Claims Administrator will not terminate the Member's coverage because of their health status, their need for Medically Necessary Covered Services or for having exercised their rights under the ***Appeal of an Administrative Denial and Medical Necessity Appeal Processes*.**

When a Subscriber's coverage terminates for any reason, coverage of the Subscriber's covered family members will also terminate.

COVERAGE CONTINUATION

When The Employee Terminates Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)
The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or eligible Dependent to temporarily extend health care coverage.

Continuation Of Coverage Pennsylvania Act 62 of 2009 (Mini-COBRA)

This subsection, and the requirements of Mini-COBRA continuation, applies to Groups consisting of two to 19 employees. This provision applies when the Subscriber is an eligible employee of the Group.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify them for continuation under this subsection, has been covered continuously for benefits under this Program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:
- The Subscriber;
- The Subscriber's Dependent spouse; or
- The Subscriber's Dependent child.

In addition, any child born to or placed for adoption with the Subscriber during Mini-COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Program during Mini-COBRA continuation, other than a child born to or placed for adoption with the Subscriber during Mini-COBRA continuation, will not be a qualified beneficiary.

- If the Subscriber Terminates Employment or Has a Reduction of Work Hours**:** If the Subscriber's group benefits end due to their termination of employment or reduction of work hours, the Subscriber may be eligible to continue such benefits for up to nine months, if:
  - The Subscriber's termination of employment was not due to gross misconduct;
  - The Subscriber is not eligible for coverage under Medicare;
  - The Subscriber verifies they are not eligible for group health benefits as an eligible Dependent; and
  - The Subscriber is not eligible for group health benefits with any other carrier.

  The continuation will cover the Subscriber and any other qualified beneficiary who loses coverage because of the Subscriber's termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the "When Continuation Ends" paragraph of this subsection.

- The Group's Responsibilities: The Group must notify the Subscriber, the benefits administrator, and the Claims Administrator, in writing, of:
  - The Subscriber's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
  - The Subscriber's death;
  - The Subscriber's divorce or legal separation from a Dependent spouse covered under this Program;
  - The Subscriber becoming eligible for benefits under Social Security;
  - The Subscriber's child ceasing to be a Dependent child pursuant to the terms of this Program;
  - Commencement of the Group's bankruptcy proceedings.

  The notice must be given to the Subscriber, the benefits administrator and the Claims Administrator no later than 30 days of any of these events.

- The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the benefits administrator or its designee of their election of continuation coverage within 30 days of receipt of the notice from the Group.

  Continuation coverage shall be effective as of the date of the event.

  Upon receipt of the Subscriber's, or the Subscriber's covered Dependent's election of continuation coverage, the benefits administrator, or its designee, shall notify the Claims Administrator of the election within 14 days.

- If the Subscriber Dies: If the Subscriber dies, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If the Subscriber's Marriage Ends: If the Subscriber's marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If a Dependent Loses Eligibility: If the Subscriber's Dependent child's group health benefits end due to their loss of dependent eligibility as defined in this Program, other than the Subscriber's coverage ending, they may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine months, subject to the "When Continued Ends" paragraph of this subsection.

- Election of Continuation: To continue their group health benefits, the qualified beneficiary must give the benefits administrator written notice that they elect to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of their continuation rights from the benefits administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Group must notify the Claims Administrator of the qualified beneficiary's election of continuation within 14 days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

  The subsequent premiums must be paid to the benefits administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the benefits administrator. No further notice of when premiums are due will be given.

  The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this Program on a regular basis. It includes any amount that would have been paid by the Group. An additional administrative charge of up to five percent of the total premium charge may also be required by the Claims Administrator.

- Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

- When Continuation Ends: A qualified beneficiary's continued group health benefits under this Program's ends on the first to occur of the following:
  - With respect to continuation upon the Subscriber's termination of employment or reduction of work hours, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to continuation upon the Subscriber's death, the Subscriber's legal divorce or legal separation, or the end of the Subscriber's covered Dependent's eligibility, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to the Subscriber's Dependent whose continuation is extended due to the Subscriber's entitlement to Medicare, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - The date coverage under this Program ends;
  - The end of the period for which the last premium payment is made;

- The date they become covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which they satisfy under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
- The date the Subscriber and/or the Subscriber's eligible Dependent become eligible for Medicare.

THE CLAIMS ADMINISTRATOR'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER MINI-COBRA ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION.

THE CLAIMS ADMINISTRATOR IS NOT THE BENEFITS ADMINISTRATOR OR PLAN ADMINISTRATOR UNDER THIS PROGRAM OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS BENEFITS ADMINISTRATOR OR PLAN ADMINISTRATOR, THE BENEFITS ADMINISTRATOR OR PLAN ADMINISTRATOR SHALL BE THE GROUP.

Conversion

If a Member or their Dependents become ineligible for coverage through their Group Program, they may apply for continuation of coverage in an appropriate non-group program. The Member must reside in Keystone's five county area in order to be eligible for the non-group HMO program. The five county area includes: Bucks, Chester, Delaware, Montgomery and Philadelphia counties. If the Member does not live in Keystone's five county area, enrollment in the HMO non-group program is provided to the Member and their Dependents for 90 days from the date the Member's Group coverage ends. After this time period, the Member and their Dependents will have to convert to another plan. The Member and their Dependents may convert to the local Blue Cross®/Blue Shield® plan for the area in which they live.

A Member's application for this conversion coverage must be made to the Claims Administrator within 30 days of when the Member becomes ineligible for Group coverage. The benefits provided under the available non-group program may not be identical to the benefits under their Group Program.

The conversion privilege is available to Members and:
- Their surviving Dependents, in the event of the Member's death;
- Their spouse, in the event of divorce; or
- Their child who has reached the Limiting Age for Dependents.

The Dependent must reside in Keystone's five county area in order to be eligible for the non-group HMO program.

This conversion privilege is not available if the Member is terminated by the Claims Administrator for cause (such as deliberate misuse of an ID Card, significant misrepresentation of information that is given to the Claims Administrator or a Provider, or fraud).

If the Member needs more information regarding their conversion privilege, call Customer Services at the telephone number shown on their ID Card.

Should the Member choose continued coverage under COBRA (see above), they become eligible to convert to an individual, non-group plan at the end of the Member's COBRA coverage.

A SUMMARY OF THE PROGRAM'S FEATURES

Confidentiality And Disclosure Of Medical Information

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

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

Member Id Card

Listed below are some important things to do and to remember about the Member's ID Card:

- Check the information on the Member's ID Card for completeness and accuracy.
- Check that the Member received one ID Card for each enrolled family member.
- Check that the name of the Primary Care Physician (or office) the Member selected is shown on the Member's ID Card. Also, please check the ID Card for each family member to be sure the information on it is accurate.
- Call Customer Service if the Member finds an error or loses their ID Card.
- Carry the Member ID Card at all times. The Member must present their ID Card whenever they receive Medical Care.

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

PROGRAM DESIGN FEATURES

This Program is different from traditional health insurance coverage. In addition to covering health care services, access is provided to Member's Medical Care through their Primary Care Physician.

All medical treatment begins with the Member's Primary Care Physician. (Under certain circumstances, continuing care by a Non-Participating Provider will be treated in the same way as if the Provider were a Participating Provider. See ***Continuity of Care*** appearing later in the Benefit Booklet.)

Because the Member's Primary Care Physician is the key to using this Program, it is important to remember the following:

- **The Member should always call their Primary Care Physician first**, before receiving Medical Care, except for conditions requiring Emergency Services. Please schedule routine visits well in advance.

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

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

- **The Member's Primary Care Physician is required to select a Designated Provider for certain Specialist Services**. Their Primary Care Physician will submit an electronic Referral to their Designated Provider for these outpatient Specialist Services:
  - Physical and Occupational Therapy;
  - Diagnostic Services for Members age five and older;
  - Laboratory and Pathology tests.

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

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

  Before selecting their Primary Care Physician, the Member may want to speak to the Primary Care Physician regarding their Designated Providers.

- **The Member's Primary Care Physician provides coverage 24 hours a day, 7 days a week.**

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

- **Some services must be authorized by the Member's Primary Care Physician or Referred Specialist or Preapproved by the Claims Administrator**. The Member's Primary Care Physician or Referred Specialist works with the Claims Administrator's Care Management and Coordination team during the Preapproval process. Services in this category include, but are not limited to: hospitalization; certain outpatient services; Skilled Nursing Facility services; and home health care. To access a complete list of services that require Preapproval, log onto www.ibx.com/preapproval, or the Member can call Customer Service at the phone number shown on their ID Card to have the list mailed to them. A Member has the right to appeal any decisions through the ***Appeal of an Administrative Denial and Medical Necessity Appeal Processes*** described later in this Benefit Booklet. Instructions for the appeal will be described in the denial notifications.

In certain circumstances the requirement for Preapproval may be altered or waived at the discretion of the Claims Administrator. The Claims Administrator may retrospectively review these services.

- **All services must be received from Participating Providers** unless Preapproved by the Claims Administrator, or except in cases requiring Emergency Services or Urgent Care while outside the Service Area.

  See Access To Primary, Specialist, And Hospital Care in this section for procedures for obtaining Preapproval for use of a Non-Participating Provider. Use the Provider Directory to find out more about the individual Providers, including Hospitals and Primary Care Physicians and Referred Specialists, and their affiliated Hospitals. It includes a foreign language index to help the Member locate a Provider who is fluent in a particular language. The directory also lists whether the Provider is accepting new patients.

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

- **Medical Technology Assessment is performed by the** Claims Administrator. Technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include and are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Claims Administrator uses the technology assessment process to assure that new drugs, procedures or devices are safe and effective before approving them as a Covered Service. When new technology becomes available or at the request of a practitioner or Member, the Claims Administrator researches all scientific information available from these expert sources. Following this analysis, the Claims Administrator makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service. A Member or their Provider should contact the Claims Administrator to determine whether a proposed treatment is considered "emerging technology" and whether the provider is considered an eligible provider to perform the "emerging technology" Covered Service. The Claims Administrator maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

- **Prescription Drugs are covered under this Program**. Under this Program Prescription Drugs, including medications and biologicals, are Covered Services or Supplies when ordered during the Member's Inpatient Hospital stay. In addition, if the Member does not have Prescription Drug coverage under this Program the Claims Administrator will provide coverage for insulin and oral agents, as well as Prescription Drugs used in the treatment of Autism Spectrum Disorders, when the Member is not an Inpatient.

  Groups may choose to provide additional Prescription Drug coverage for Prescription Drugs for use when a Member is not an Inpatient. The benefits and cost sharing will vary depending upon the program chosen. That coverage may also include a Drug Formulary. If so, the Member will be given a copy of the Drug Formulary, and the coverage may exclude, or require the Member to pay higher Copayments for certain Prescription Drugs. To obtain a copy of the Drug Formulary, the Member should call Customer Service at the phone number shown on their ID Card.

Prescription Drug benefits do not cover over-the-counter drugs except insulin.

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

The Claims Administrator, for all Prescription Drug benefits, requires Preapproval of a small number of drugs approved by the FDA for use in specific medical conditions. Where Preapproval or quantity limits are imposed, the Member's Physician may request an exception for coverage by providing documentation of Medical Necessity. The Member may obtain information about how to request an exception by calling Customer Service at the phone number on their ID Card.

The Member, or their Physician acting on their behalf, may appeal any denial of benefits or application of higher cost sharing through the ***Appeal of an Administrative Denial and Medical Necessity Appeal Processes*** described later in this Benefit Booklet.

Discretionary Authority
The Claims Administrator retains discretionary authority to interpret this Program and the facts presented to make benefit determinations. Benefits under this Program will be provided only if the Claims Administrator determines in its discretion that the Member is entitled to them.

(Keystone) Out-Of-Area Services

Overview

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

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

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

A. BlueCard® Program

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

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

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

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

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

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

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

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

B. Non-Participating Healthcare Providers Outside Keystone's Service Area

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.

C. Blue Cross Blue Shield Global Core

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

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

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

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

ACCESS TO PRIMARY, SPECIALIST, AND HOSPITAL CARE

Direct Access To Certain Care

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

- Emergency Services;
- Care from a participating obstetrical/gynecological Specialist;
- Mammograms;
- Mental Health Care, Serious Mental Illness Health Care and Alcohol Or Drug Abuse And Dependency;
- Inpatient Hospital Services that require Preapproval. This does not include a maternity Inpatient Admission;
- Dialysis services performed in a Participating Facility Provider or by a Participating Professional Provider;
- Nutrition Counseling;
- Diabetic Education Program;

How To Obtain A Specialist Referral

The Member should always consult their Primary Care Physician first when they need Medical Care.

If the Member's Primary Care Physician refers them to a Referred Specialist or facility just follow these steps:

- The Member's Primary Care Physician will submit an electronic Referral indicating the services authorized.
- The Member's Referral is valid for 90 days from issue date as long as they are a Member.
- This form is sent electronically to the Referred Specialist or facility before the services are performed. Only services authorized on the Referral form will be covered.
- Any additional Medically Necessary treatment recommended by the Referred Specialist beyond the 90 days from the date of issue of the initial Referral will require another electronic Referral from the Member's Primary Care Physician.
- The Member must be enrolled at the time they receive services from a Referred Specialist or Non-Participating Provider in order for services to be covered.

See the ***Preapproval for Non-Participating Providers*** section of the Benefit Booklet for information regarding services provided by Non-Participating Providers.

How To Obtain A Standing Referral

If the Member has a life-threatening, degenerative or disabling disease or condition, they may receive a Standing Referral to a Participating Professional Provider to treat that disease or condition. The Referred Specialist will have clinical expertise in treating the disease or condition. A Standing Referral is granted upon review of a treatment plan by the Claims Administrator and in consultation with the Member's Primary Care Physician.
Follow these steps to initiate a Standing Referral request.

- Call Customer Service at the telephone number shown on the Member's ID Card. (Or, the Member may ask their Primary Care Physician to call Provider Services or Care Management and Coordination to obtain a "Standing Referral Request" form.)

- A "Standing Referral Request" form will be mailed or faxed to the requestor.
- The Member must complete a part of the form and their Primary Care Physician will complete the clinical part. The Member's Primary Care Physician will then send the form to Care Management and Coordination.
- Care Management and Coordination will either approve or deny the request for the Standing Referral. The Member, their Primary Care Physician and the Referred Specialist will receive notice of the approval or denial in writing. The notice will include the time period for the Standing Referral.

If the Standing Referral is Approved

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

If the Standing Referral is Denied

If the request for a Standing Referral is denied, the Member and their Primary Care Physician will be informed in writing. The Member will be given information on how to file a formal appeal, if they so desire.

Designating A Referred Specialist As A Member's Primary Care Physician

If the Member has a life-threatening, degenerative or disabling disease or condition, they may have a Referred Specialist named to provide and coordinate both their primary and specialty care. The Referred Specialist will be a Physician with clinical expertise in treating their disease or condition. It is required that the Referred Specialist agrees to meet the Program’s requirements to function as a Primary Care Physician.

Follow these steps to initiate a request for a Member's Referred Specialist to be their Primary Care Physician.

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

If the Referred Specialist as Primary Care Physician Request is Approved
If the request for the Referred Specialist to be the Member's Primary Care Physician is approved, the Referred Specialist, the Member's Primary Care Physician and the Member will be informed in writing by Care Management and Coordination.

If the Referred Specialist as Primary Care Physician Request is Denied
If the request to have a Referred Specialist designated to provide and coordinate the Member's primary and specialty care is denied, the Member and their Primary Care Physician will be informed in writing. The Member will be given information on how to file a formal appeal, if they so desire.

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

- submitting in writing, calling the telephone number shown on the back of the Member ID Card, or using the IBX Mobile app to the Health Benefit Plan's Customer Service Department, or
- logging into the website at www.ibx.com/login and selecting Account Settings and Member Information.

The change will become effective on the earlier of:

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

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

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

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

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

Changing A Member's Referred Specialist
The Member may change the Referred Specialist to whom they have been referred by their Primary Care Physician or for whom the Member has a Standing Referral. To do so, the Member asks their Primary Care Physician to recommend another Referred Specialist before services are performed. Or, the Member may call Customer Service at the telephone number shown on their ID Card. Remember, only services authorized on the Referral form will be covered.

If the participating status of a Referred Specialist the Member regularly visit changes, they will be notified to select another Referred Specialist.

Continuity Of Care
The Member has the option, if their Physician agrees to be bound by certain terms and conditions as required by the Claims Administrator, of continuing an ongoing course of treatment with that Physician. This continuation of care shall be offered through the current period of active treatment for an acute condition or through the acute phase of a chronic condition or for up to 90 calendar days from the notice that the status of the Member's Physician has changed or the Member's
Effective Date of Coverage when:

- The Member's Physician is no longer a Participating Provider because the Claims Administrator terminates its contract with that Physician, for reasons other than cause; or
- The Member first enrolls in this Program and is in an ongoing course of treatment with a Non-Participating Provider.

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

The Member should follow these steps to initiate their continuity of care:

- Call Customer Service at the number on the Member's ID Card and ask for a "Request for Continuation of Treatment" form.
- The "Request for Continuation of Treatment" form will be mailed or faxed to the Member.
- The Member must complete the form and send it to Care Management and Coordination at the address that appears on the form.

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

The Member will be notified when the participating status of their Primary Care Physician changes so that they can select another Primary Care Physician.

Preapproval For Non-Participating Providers
The Claims Administrator may approve payment for Covered Services provided by a Non-Participating Provider if the Member has:

- First sought and received care from a Participating Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the Non-Participating Provider that the Member has requested. (The Member's Primary Care Physician is required to obtain Preapproval from the Claims Administrator for services provided by a Non-Participating Provider.);
- Been advised by the Participating Provider that there are no Participating Providers that can provide the requested Covered Services; and
- Obtained authorization from the Claims Administrator prior to receiving care. The Claims Administrator reserves the right to make the final determination whether there is a Participating Provider that can provide the Covered Services.

If the Claims Administrator approves the use of a Non-Participating Provider, the Member will not be responsible for the difference between the Provider's billed charges and the Claims Administrator's payment to the Provider but the Member will be responsible for applicable cost-sharing amounts.

If the Member receives any bills from the Provider, they need to contact Customer Service at the telephone number on their ID card. When the Member notifies the Claims Administrator about these bills, the Claims Administrator will resolve the balance billing.

Hospital Admissions

- If the Member needs hospitalization or outpatient Surgery, the Member's Primary Care Physician or Referred Specialist will arrange admission to the Hospital or outpatient surgical facility on their behalf.
- The Member's Primary Care Physician or Referred Specialist will coordinate the Preapproval for their outpatient Surgery or Inpatient admission with the Claims Administrator, and the Claims Administrator will assign a Preapproval number. Preapproval is not required for a maternity Inpatient Admission.
- The Member does not need to receive an electronic Referral from their Primary Care Physician for Inpatient Hospital Services that require Preapproval.

Upon receipt of information from the Member's Primary Care Physician or Referred Specialist, Care Management and Coordination will evaluate the request for hospitalization or outpatient Surgery based on clinical criteria guidelines. Should the request be denied after review by a Claims Administrator Medical Director, the Member, their Primary Care Physician or their Referred Specialist has a right to appeal this decision through the Medical Necessity Appeal process.

During an Inpatient hospitalization, Care Management and Coordination is monitoring the Member's Hospital stay to assure that a plan for their discharge is in place. This is to make sure that the Member has a smooth transition from the Hospital to home, or to another setting such as a Skilled Nursing or Rehabilitation Facility. A Claims Administrator Case Manager will work closely with the Member's Primary Care Physician or Referred Specialist to help with their discharge and if necessary, arrange for other medical services.

Should the Member's Primary Care Physician or Referred Specialist agree with the Claims Administrator that Inpatient hospitalization services are no longer required, the Member will be notified in writing of this decision. Should the Member decide to remain hospitalized after this notification, the Hospital has the right to bill the Member after the date of the notification. The Member may appeal this decision through the Medical Necessity Appeal process.

Recommended Plan Of Treatment

The Member agrees, when enrolling in this Program, to receive care according to the recommendations of their Primary Care Physician or Referred Specialist. The Member has the right to give their informed consent before the start of any procedure or treatment. The Member also has the right to refuse any drugs, treatment or other procedure offered to them by providers in the Claims Administrator's network, and to be informed by their Physician of the medical consequences of their refusal of any drugs, treatment, or procedure.

The Claims Administrator and the Member's Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if the Member still refuses the recommended Plan of Treatment, the Claims Administrator will not be responsible for the costs of further treatment for that condition and the Member will be so notified. The Member may use the Medical Necessity Appeal process to have their case reviewed, if they so desire.

Special Circumstances
In the event that Special Circumstances result in a severe impact to the availability of Providers and services, to the procedures required for obtaining benefits for Covered Services under this Program described in this Benefit Booklet (For example, obtaining Referrals, use of Participating Providers), or to the administration of this Program by the Claims Administrator, the Claims Administrator may, on a selective basis, waive certain procedural requirements or cost-sharing of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period of time as is required by the Special Circumstances as defined below.

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

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

- A major disaster;
- An epidemic;
- A pandemic;
- Riot;
- Civil insurrection;
- Public health emergency; or
- The complete or partial destruction of facilities

Member Liability
Except when certain cost sharing is specified in this Benefit Booklet or on the ***Schedule of Covered Services***, the Member is not liable for any charges for Covered Services when these services have been provided or Referred by their Primary Care Physician and they are eligible for such benefits on the date of service.

Right To Recover Payments Made In Error
If the Claims Administrator should provide coverage for any contractually excluded services through inadvertence or error, the Claims Administrator maintains the right to seek recovery of such payment from the Provider or Member to whom such payment was made.

INFORMATION ABOUT PROVIDER REIMBURSEMENT

The Claims Administrator reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for our Members. Set forth below is a general description of the Claims Administrator reimbursement programs, by type of participating health care provider. These programs vary by state.

Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If after reading this material the Member has any questions about how their health care provider is compensated, please speak with them directly or contact Customer Service.

Professional Providers

Primary Care Physicians: Most Primary Care Physicians (PCPs) are paid in advance for their services, receiving a set dollar amount per Member, per month for each Member selecting that PCP. This is called a capitation payment and it covers most of the care delivered by the PCP. Covered Services not included under capitation are paid fee-for-service according to the Claims Administrator fee schedule. Many Pennsylvania based PCPs are also eligible to receive additional payments for meeting certain medical quality, patient service and other performance standards. In Pennsylvania, the PCP Quality Incentive Payment System (QIPS) includes incentives for practices that have extended hours and submit encounter and referral data electronically, as well as an incentive that is based on the extent to which a PCP prescribes generic drugs (when available) relative to similar PCPs. In addition, the Practice Quality Assessment Score focuses on preventive care and other established clinical interventions.

Referred Specialists: Most Referred Specialists are paid on a fee-for-service basis, meaning that payment is made according to the Claims Administrator's fee schedule for the specific medical services that the Referred Specialist performs. Obstetricians are paid global fees that cover most of their professional services for prenatal care and for delivery.

Designated Providers: For a few specialty services, PCPs are required to select a Designated Provider to which they refer all of the Claims Administrator's patients for those services. The Specialist services for which PCPs must select a Designated Provider vary by state and could include, but are not limited to, radiology and Physical Therapy. Designated Providers usually are paid a set dollar amount per Member per month (capitation) for their services based on the PCPs that have selected them. Before selecting a PCP, Members may want to speak to the PCP regarding the Designated Provider that PCP has chosen.

Hospital-Based Provider: When the Member receives Covered Services from a Hospital-Based Provider while they are an Inpatient at a Participating Hospital or other Participating Facility Provider and are being treated by a Participating Professional Provider, the Member may receive Covered Services provided by a Non-Participating Hospital-Based Provider. For such Covered Services, the Health Benefit Plan will reimburse the Non-Participating Hospital-Based Provider based upon the methodology established by the Consolidated Appropriations Act (CAA). The Member is protected from surprise billing, cannot be balanced billed, and will be subject to the in-network cost-sharing levels by the Non-Participating Hospital-Based Provider, and the Non-Participating Hospital-Based Provider cannot ask the Member to give up their protections not to be balanced billed.

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

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

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

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

Institutional Providers

Hospitals: For most inpatient medical and surgical Covered Services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Member is in the Hospital. These rates usually vary according to the intensity of services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, (For example, transplants).

For most outpatient and Emergency Covered Services and procedures, most Hospitals are paid specific rates based on the type of service performed. Hospitals may also be paid a global rate for certain outpatient Covered Services (For example, lab and radiology) that includes both the facility and Physician payment. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various Covered Services.

Some Hospitals participate in a quality incentive program. The program provides increased reimbursement to these Hospitals when they meet specific quality and other criteria, including "Patient Safety Measures.". " Such patient safety measures are consistent with recommendations by The Leap Frog Group, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Agency for Health Care Research and Quality (AHRQ) and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes and electronic submissions. This incentive program is expected to evolve over time.

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

Ambulatory Surgical Centers (ASCs)

Most ASCs are paid specific rates based on the type of service performed. For a few Covered Services, some ASCs are paid based on a percentage of billed charges.

Integrated Delivery Systems: In a few instances, we have global payment arrangements with integrated Hospital/Physician organizations called Integrated Delivery Systems (IDS). In these cases the IDS provides or arranges for some of the Hospital, Physician and ancillary Covered Services provided to some of our Members who select PCPs which are employed by or participate with the IDS.

The IDS is paid a global fee to cover all such Covered Services, whether provided by the IDS or other Providers. These IDSs are therefore “at risk” for the cost of these Covered Services. Some of these IDSs may provide incentives to their IDS-affiliated Professional Providers for meeting certain quality, service or other performance standards.

Physician Group Practices and Physician Associations

Certain Physician group practices and independent Physician associations (IPAs) employ or contract with individual Physicians to provide medical Covered Services. These groups are paid as outlined above. These groups may pay their affiliated Physicians a salary and/or provide incentives based on production, quality, service, or other performance standards. In Pennsylvania, we have entered into a joint venture with an IPA. This IPA is paid a global fee to cover the cost of all Covered Services, including Hospital, professional and ancillary Covered Services provided to Members who choose a PCP in this IPA. This IPA is therefore “at risk” for the cost of these Covered Services. This IPA provides incentives to its affiliated Physicians for meeting certain quality, service and performance standards.

Ancillary Service Providers

Some ancillary service providers, such as Durable Medical Equipment and Home Health Care Providers, are paid fee-for-service payments according to the Claims Administrator fee schedule for the specific medical services performed. Other ancillary service providers, such as those providing laboratory, dental or vision Covered Services, are paid a set dollar amount per Member per month (capitation). Capitated ancillary service vendors are responsible for paying their contracted providers and do so on a fee-for-service basis.

Mental Health/ Alcohol Or Drug Abuse And Dependency

A Mental Health/Alcohol Or Drug Abuse And Dependency ("behavioral health") management company administers most of the behavioral health benefits and provides a network of Participating Behavior Specialists. The behavioral health management company is paid a set dollar amount per Member per month (capitation) for each Member and is responsible for paying its contracted providers on a fee-for-service basis. The contract with the behavioral health management company includes performance-based payments related to quality, provider access, service, and other such parameters.

A subsidiary of Independence Blue Cross has a less than one percent ownership interest in this behavioral health management company.

UTILIZATION REVIEW PROCESS AND CRITERIA

Utilization Review Process

Two conditions of this Program are that in order for a health care service to be covered or payable, the service must be:

- Eligible for coverage under this Program; and,
- Medically Necessary.

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

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

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

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

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

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

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

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

The following are general examples of current Precertification or Preapproval requirements under benefit plans; however these requirements vary by benefit plan and state and are subject to change:
- Hysterectomy;
- Nasal Surgery procedures;
- Bariatric Surgery; and
- Potentially cosmetic or Experimental/Investigative Services.

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

Retrospective Review
Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Claims Administrator not being notified of a Member's Inpatient Admission until after discharge or where medical charts are unavailable at the time of a required concurrent review. Certain services are only reviewed on a retrospective basis.

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

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

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

CLINICAL CRITERIA, GUIDELINES AND RESOURCES

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

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

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

- Some elective surgeries--settings for Inpatient and Outpatient procedures (For example, hysterectomy and sinus Surgery);
- Inpatient Hospital Services;
- Inpatient rehabilitation care;
- Home Health Care;
- Durable Medical Equipment (DME); and
- Skilled Nursing Facility Services.

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

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

The Claims Administrator's medical polices may be applied for Covered Services including, but not limited to the following:

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

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

DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

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

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

COORDINATION OF BENEFITS

If a Member or any of their Dependents have other group health insurance coverage which provides benefits for Hospital, medical, or other health expenses, the Member's benefit payments may be subject to Coordination of Benefits (COB). COB refers to the administration of health benefit coverage when a person is covered by more than one group plan. COB provisions:

- Determine which health plan will be the primary payor and which will be the secondary payor;
- Regulate benefit payments so that total payments by all insurers do not exceed total charges for Covered Services;
- Apply to all Member benefits, however, the Claims Administrator will provide access to Covered Services first and apply the applicable COB rules later;
- Allow the Claims Administrator to recover any expenses paid in excess of its obligation as a non-primary payor; and
- Apply to services for the treatment of injury resulting from the maintenance or use of a motor vehicle.

Coordination of Benefits Administration

Determination will be made as to whether the Member is also entitled to receive benefits under any other group health care insurance plan or under any governmental program for which any periodic payment is made by or for the Member, with the exception of student accident plans, group hospital indemnity plans paying $100 per day or less and, if provided under the Member's Program, coverage for vision expenses. If so, the Claims Administrator shall determine whether the other insurer or government plan has primary responsibility for payment. In these cases, the payment under this Program may be reduced or eliminated. The Claims Administrator will provide access to Covered Services first and determine liability later.

If it is determined that this Program is the secondary plan, the Claims Administrator has the right to recover the expense already paid in excess of this Program's liability as the secondary plan. In such cases, only care provided or Referred by the Member's Primary Care Physician will be covered by this Program as secondary. The Member is required to furnish information and to take such other action as is necessary to assure the rights of the Claims Administrator. In determining whether this Program or another group health plan has primary liability the following will apply.

- If another plan under which an individual has coverage with does not have a COB provision, that plan will be primary and this Program will be secondary. In order for services to be covered by this Program as secondary, the Member's care must be provided or Referred by their Primary Care Physician.
- If the other plan does include a Coordination of Benefits or non-duplication provision:
  - The plan which covers an individual as a Subscriber (meaning not a dependent) will be primary. The plan which covers the individual as a dependent will be secondary;
  - If there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan;

- Where both plans cover a child as a dependent, the plan of the parent whose date of birth (excluding year) occurs earlier in the calendar year will be primary (the Birthday Rule). If both parents have the same birthday, the plan covering the parent longer will be primary. If the other plan does not include this provision, the provisions of that plan will determine the order of benefits.
- If parents are separated or divorced, and no court decree applies, the benefits for the child will be determined as follows:
  - The plan of the parent with custody of the child will be primary;
  - The plan of the spouse of the parent with custody of the child will be secondary;
  - The plan of the parent not having custody of the child will be third;
  - In cases of joint custody, benefits will be determined by the Birthday Rule.
- Where there is a court decree which establishes financial responsibility for the health care expenses of the child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan.
- In cases of joint custody, benefits will be determined by the Birthday Rule as described in the second bulleted item above regarding the " Coordination of Benefits or non-duplication provision".

- The benefits of a plan covering the patient as a laid-off or retired employee or as the Dependent of a laid-off or retired employee shall be determined after the benefits of any other plan covering such person as an employee or dependent of such person. If the other plan does not have the rule regarding laid-off or retired employees, and if, as a result, the plans do not agree on the order of benefits, the rule will be ignored.
- Where the determination cannot be made in accordance with the preceding paragraphs, the plan which has covered the patient for the longer period of time will be the primary plan.
- Expenses for the treatment of injury arising out of the maintenance or use of a motor vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:
  - Under a plan or policy of motor vehicle insurance, provided that non-duplication as contained herein is not prohibited by law; or
  - Through a program or other arrangement of qualified or certified self-insurance.
- The Claims Administrator may release to or obtain from any person or organization any information about coverage, expenses and benefits, which may be necessary to determine whether this Program has the primary responsibility of payment. For the purpose of COB, if the Member receives services or supplies available under this Benefit Booklet but such is not provided by nor Referred by the Member's Primary Care Physician payment will not be made by this Program except as provided under this Benefit Booklet.
- Services provided under any governmental program for which any periodic payment is made by or for the Subscriber shall always be the primary plan, except where prohibited by law.

This provision does not apply to an individual health care plan issued to or in the name of the Member.

SUBROGATION AND REIMBURSEMENT RIGHTS

The Employee Retirement Income Security Act (ERISA) applies to many health benefit plans and, to comply with legal requirements that relate specifically to ERISA-governed plans, this Benefit Booklet describes "Subrogation and Reimbursement Rights" in two sections:

- Subrogation and Reimbursement Rights When The Program Is Governed By ERISA; and
- Subrogation and Reimbursement Rights When The Program Is Not Governed By ERISA.

However, the fact that these Rights are described in separate sections using different language does not mean or imply that the Rights are substantively different or that the Rights described in one section are greater or lesser than the Rights described in the other section. Under both sections, the Health Benefit Plan reserves right the pursue subrogation recoveries and the Member has an obligation to fully reimburse the Health Benefit Plan to the fullest extent permitted by law.

- **Subrogation and Reimbursement Rights When The Program Is Governed By ERISA**

  By accepting benefits for Covered Services, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

  The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

  Subrogation Rights
  Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights
If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The Health Benefit Plan has a right to full reimbursement.

Lien
By accepting benefits for Covered Services from the Health Benefit Plan, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Health Benefit Plan the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Health Benefit Plan has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Health Benefit Plan is reimbursed in full.

Constructive Trust
If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Health Benefit Plan has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Health Benefit Plan to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Health Benefit Plan.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Health Benefit Plan is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Health Benefit Plan will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing. The recovery rights of the Health Benefit Plan will not be reduced by the "common fund" doctrine.

- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
- Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Health Benefit Plan's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Health Benefit Plan or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Health Benefit Plan paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

- **Subrogation and Reimbursement Rights When The Program Is Not Governed By ERISA**

By accepting benefits for Covered Services, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights to the extent permitted by law. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

Subrogation Rights
Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights
If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, to the extent permitted by law.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
- Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Health Benefit Plan's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Health Benefit Plan or its designated representative promptly, if appropriate, upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

IMPORTANT: Failure to Cooperate

If you fail or refuse to sign forms or documents as requested or otherwise fail or refuse to cooperate or abide by any of the obligations described above, the Claims Administrator or Plan Administrator, as applicable, has full discretion and authority to reduce or withhold benefit payments to recover subrogation/reimbursement amounts that are owed and/or to terminate your participation in the benefit program.

CLAIM PROCEDURES

Most claims are filed by Providers in the Claims Administrator’s network. The following applies if the Member must submit a claim.

Notice of Claims

The Claims Administrator will not be liable for any claims under this Program unless proper notice is furnished to the Claims Administrator that Covered Services in this Program have been rendered to a Member.

Written notice of a claim must be given to the Claims Administrator within 20 days, or as soon as reasonably possible after Covered Services have been rendered to the Member. Notice given by or on behalf of the Member to the Claims Administrator that includes information sufficient to identify the Member that received the Covered Services, shall constitute sufficient notice of a claim to the Claims Administrator.

The Member can give notice to the Claims Administrator by calling Customer Service. The telephone number and address of Customer Service can be found on the Member*'s* ID Card. A charge shall be considered Incurred on the date a Member receives the Covered Service for which the charge is made.

Proof of Loss
Claims cannot be paid until a written proof of loss is submitted to the Claims Administrator. Written proof of loss must be provided to the Claims Administrator within 90 days after the charge for Covered Services is Incurred. Proof of loss must include all data necessary for the Claims Administrator to determine benefits. Failure to submit a proof of loss to the Claims Administrator within the time specified will not invalidate or reduce any claim if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event, except in the absence of legal capacity, will the Claims Administrator be required to accept a proof of loss later than 12 months after the charge for Covered Services is Incurred.

Claim Forms
If a Member (or if deceased, by their personal representative) is required to submit a proof of loss for benefits under this Program, it must be submitted to the Claims Administrator on the appropriate claim form. The Claims Administrator, upon receipt of a notice of claim will, within 15 days following the date notice of claim is received; furnish to the Member claim forms for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of such notice, the Member shall be deemed to have complied with the requirements of this subsection as to filing a proof of loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for Covered Services as described below. Itemized bills may be submitted to the Claims Administrator at the address appearing on the Member's ID Card. Itemized bills cannot be returned.

Submission of Claims Forms
For Member-submitted claims, the completed claim form, with all itemized bills attached, must be forwarded to the Claims Administrator at the address appearing on the claim form in order to satisfy the requirement of submitting a written proof of loss and to receive payment for benefits provided under this Program.

To avoid delay in handling Member-submitted claims, answers to all questions on the claim form must be complete and correct. Each claim form must be accompanied by itemized bills showing all of the following information:
- Person or organization providing the service or supply;
- Type of service or supply;
- Date of service or supply;
- Amount charged; and
- Name of patient.

A request for payment of a claim will not be reviewed and no payment will be made unless all the information and evidence of payment required on the claim form has been submitted in the manner described above. The Claims Administrator reserves the right to require additional information and documents as needed to support a claim that a Covered Service has been rendered.

Timely Payment of Claims
Claims payment for benefits payable under this Program will be processed immediately upon receipt of proper proof of loss.

Physical Examinations and Autopsy
The Health Benefit Plan at its own expense shall have the right and opportunity to examine the Member when and so often as it may reasonably require during the pendency of claim under the Contract; and the Health Benefit Plan shall also have the right and opportunity to make an autopsy in case of death, where it is not prohibited by law.

Payment of Claims
If any indemnity of the Contract shall be payable to the estate of the Member, or to a Member or beneficiary who is a minor or otherwise not competent to give a valid release, the Health Benefit Plan may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Member or beneficiary who is deemed by the Health Benefit Plan to be equitably entitled thereto. Any payment made by the Health Benefit Plan in good faith pursuant to this provision shall fully discharge the Health Benefit Plan to the extent of such payment.

Time Limit on Certain Defenses
After three (3) years from the date of issue of the Contract, no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Contract, shall be used to void said Contract or to deny benefits for a claim incurred commencing after the expiration of such three (3) year period.

Legal Action
No legal action may be commenced against the Health Benefit Plan with respect to the Contract until at least sixty (60) days after the Health Benefit Plan has received a properly completed claim form, Referral or encounter form. No legal action against the Health Benefit Plan with respect to the Contract may be filed later than three (3) years after the Covered Services or supplies were performed or provided.

In addition, no legal action regarding an Appeal of an Administrative Denial or Medical Necessity Appeal may be commenced against the Health Benefit Plan until the Member has exhausted their administrative remedies and appeals as detailed in this Contract.

APPEAL OF AN ADMINISTRATIVE DENIAL AND MEDICAL NECESSITY APPEAL PROCESS

COMPLAINT AND APPEAL PROCESS

Informal Member Complaint Process
The Claims Administrator has a process for Members to express informal Complaints. To register a Complaint (as opposed to an Appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their Identification Card or write to the Claims Administrator at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated, and the Member will receive a response in writing within 30 days.

Member Appeal Process

Filing an Appeal

The Claims Administrator maintains procedures for the resolution of Member Appeals. Internal Appeals may be filed within 180 calendar days of the Member's or designee's receipt of an adverse benefit determination from the Claims Administrator. The Member may designate either the Provider or another authorized representative to represent the Member on the Appeal. After obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the Appeal, the Member must complete a valid authorization form. The Member should contact the Claims Administrator as directed below to obtain a "Member/Enrollee Authorization to Appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an Appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department	Toll Free Phone: 1-888-671-5276
P.O. Box 41820	Toll Free Fax: 1-888-671-5274
Philadelphia, PA, 19101-1820	Philadelphia Fax: 215-988-6558

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

The Claims Administrator will not terminate or reduce an-ongoing course of treatment without providing the Member or designee with advance notice and the opportunity for advanced review.

Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited Appeals process.

If the Appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Member may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the Appeal and their understanding of the nature of the Appeal. The Member or designee may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.

Types of Appeals

Following are the two types of Appeals and the issues they address:

- **Internal Standard (non-urgent) Medical Necessity Appeals** - An Appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity Appeals include Appeals of adverse benefit determinations based on medical judgement and the exclusions for Experimental/Investigative or cosmetic services. A Claim Administrator's Medical Director (MDR) is the decision maker for Medical Necessity Appeals. This individual holds an active unrestricted license to practice medicine. Either the Claim Administrator's MDR or an independent consultant function as the same/similar specialist. The same/similar specialist is in the same/similar specialty as the individual who is managing the Member's care, The independent consultant is a licensed Physician, Psychologist, or other health care professional, who has no previous involvement with the case and is not a subordinate of anyone previously involved in the case.

  For each of the two levels of Medical Necessity Appeal, a different MDR is the decider of the Appeal. For both levels of Appeal, the MDR has no previous involvement with the case and is not a subordinate of anyone previously involved.

  The same/similar specialist review is typically part of the first level Appeal. However, if additional information is submitted prior to the second level of Appeal, an MDR or independent consultant who has no previous involvement with the case and is not the subordinate of anyone who was previously involved in the case, conducts a second same/similar specialist review.

- **Administrative Appeal** - A dispute or objection by a Member regarding the following: operations or management policies of a health care plan, non-covered services, coverage limitations, participating or non-participating provider status, cost sharing requirements, certain surprise medical bills received by a Member from an out-of-network Provider, and rescissions of coverage (except for failure to pay premiums or coverage contributions), that has not been resolved by the Claims Administrator. An employee of the Claims Administrator is the decision maker for the level 1 Administrative Appeal. This individual has had no previous involvement with the case and is not a subordinate of anyone involved with a previous adverse determination. A different employee of the Claims Administrator decides the level 2 Appeal. This individual has no prior involvement in the case and is not the subordinate of anyone previously involved.

Internal Standard Appeals

Pre-service Appeal - An Appeal for benefits that, under the terms of this Group Program Document, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained for coverage to be available. For a standard Pre-Service Appeal, a maximum of 15 calendar days is available for each of the two levels of internal Appeal.

Post-service Appeal - An Appeal for benefits that is not a Pre-service Appeal. (Post-service Appeals concerning claims for services that the Member has already obtained do not qualify for review as Expedited/Urgent Appeals.) For a standard Post-Service Appeal, a maximum of 30 calendar days is available for each of the two levels of internal Appeal.

For prescription non-formulary exception requests, the decision is made, and notification is sent to the Member/designee within 72 hours for each level of Appeal.

The decision of the Claims Administrator is sent to the Member or designee in writing within the timeframe noted above.

Internal Urgent/Expedited Appeals Review:
An urgent expedited Appeal is any Appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Appeal.

The Appeals review process for an urgent/expedited Appeal mirrors the process described above under the section entitled "Types of Appeal".

The expedited review is completed promptly based on the Member's health condition, but no later than 72 hours after receipt of the expedited Appeal request by the Claims Administrator. Within 72 hours after receipt of the expedited Appeal, the Claims Administrator notifies the Member or designee by telephone of the determination. The determination is sent in writing within 72 hours after the Member or designee has received the verbal notification.

For prescription non-formulary exception requests, the Claims Administrator notifies the Member or designee of the determination in writing within 24 hours after the receipt of the request from the Member or designee.

The Member or designee may also file an expedited external Medical Necessity Appeal at the same time as filing an internal expedited Medical Necessity Appeal.

If not satisfied with the standard or expedited decision from the Claims Administrator, the Member or designee has the right to initiate an external Appeal as described below.

External Review Process via an Independent Review Organization (IRO)

Types of Services Eligible for An External Review
Under the Federal Independent Review Organization (IRO) process, Members or their designee may request an External Review that is based on any of the following:

- Medical Necessity and medical judgement Appeals, including when a health care Provider requests an authorization for additional treatment that was not approved by the Plan.
- Appropriateness of service.
- Health care setting.
- Effectiveness of a covered benefit.
- Level of care.

When a Member seeks coverage for specialized care from an out-of-network health care Provider because they believe that an in-network health care Provider cannot effectively do the procedure or manage their care.

Disputes regarding the Program's compliance with the surprise billing and cost-sharing protections under Sections 2799a-1 and 2799a-2 of the Public Health Services Act and regulations promulgated thereunder, including:

- Any determination of whether an Appeal is for emergency services or for consideration of compliance with the cost sharing and surprise billing protections.
- Clarification as to whether a claim for items and/or services from non-participating health care Providers at an in-network facility are subject to the No Surprise Act protections.
- Clarification as to whether an individual was in a condition to receive a notice about the No Surprise Act protections and have given informed consent to waive those protections.

Determine whether a claim for services and items is coded correctly and consistent with the treatment the individual received.

Determine whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network health care Provider at an in-network facility.

Rescissions of coverage, except for non-payment of premiums or coverage contributions

Standard External Review Process - The Claims Administrator follows the Federal Independent Review Organization (IRO) Process. The Member or designee may request an External Review via an IRO by calling or writing to the Claims Administrator within four months of receipt of the internal Appeal decision letter. The Member or designee is not required to pay any of the costs associated with the External Review.

The Member or designee may only request an External Review after exhausting the Claims Administrator's internal Appeal process. The Member or designee shall be deemed to have exhausted the internal Appeal process if the Claims Administrator has failed to comply with the requirements of the internal claims, utilization review and or Appeals process, unless the failure or failures are based on de minimis (minor) violations that do not cause and are not likely to cause prejudice or harm to the Member or designee.

Preliminary Review

Within five business days of the Claims Administrator's receipt of an External Appeal request from the Member or designee, the Claims Administrator conducts a preliminary review of the request to determine the following:

- The Member is or was covered at the time the health care service or item was requested (in the case where services or items require pre-authorization) or provided in the case of retrospective reviews.
- The adverse benefit determination or final adverse benefit determination does not relate to the Member's failure to meet the eligibility requirements under the terms of the Program.
- The Member has exhausted the Program's internal Appeal process.
- The Member has provided all the information and forms required to process an external Appeal.

Within one business day after completion of the preliminary review, the Claims Administrator sends written notification to the Member or designee. If the request is complete but not eligible for an external review, the notice must include the reasons for the lack of ineligibility. If additional information or material is needed for the Claims Administrator to process the external Appeal request, the notification identifies that information. The Member or designee has 48 hours from their receipt of the notification to submit the required information to the Claims Administrator.

If the request is eligible, the Claims Administrator assigns the external review to an IRO which is accredited by a nationally recognized accrediting organization such as NCQA (National Committee for Quality Assurance). The IRO referral process provides for the following:

- The Claims Administrator ensures that the IRO process is not biased.
- The Claims Administrator contracts with four separate IROs and rotates assignments among them.
- As required by Federal law, the IRO is not eligible for financial incentives based on the likelihood they will support the denial.
- The IRO has no direct or indirect professional, familial, or financial conflicts of interest with the Claims Administrator, with the Member, or the designee. The Claims Administrator's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest.
- The consultant assigned by the IRO to review the Appeal request, has no prior involvement with the case and is not a subordinate of anyone previously involved.
- The assigned consultant is in the same/similar specialty as the individual managing the Member's care.

Within five business days of the IRO assignment, the Claims Administrator sends the IRO all the information and documents considered in making the adverse determination electronically via the applicable IRO portal.

For a standard external review, the IRO makes the decision and sends notification to the Member or designee within 45 calendar days of their receipt of the request. For prescription non-formulary exception requests, the IRO sends notification to the Member or designee within 72 hours of their receipt of the request.

Expedited External Review Process

The Member or designee may request an External Review for urgent/expedited situations through an IRO. Additionally, the Member or the designee may request a concurrent internal and external expedited external review. The Member or designee is not required to pay any of the costs.

Preliminary Review - Immediately upon request for an external expedited Appeal, the Claims Administrator determines the eligibility and reviewability of the request as follows.

- The Member is or was covered at the time the health care service or item was requested (in the case where services or items require pre-authorization) or provided in the case of retrospective reviews.
- The adverse benefit determination or final adverse benefit determination does not relate to the Member's failure to meet eligibility requirements under the terms of the Program.
- The Member has provided all the information and forms required to process an expedited external Appeal.

Upon determination that an expedited external review request is eligible for an external review, the Claims Administrator assigns an IRO and electronically sends all information and documents considered in the adverse benefit determination to the IRO via the applicable portal.

The IRO reviews the case file, makes a decision, and sends notification to the Member or designee within 72 hours of their receipt of the external Appeal request. For prescription non-formulary exception requests, the IRO reviews the case file, makes the decision, and notifies the Member or designee within 24 hours of their receipt of the request.

All IRO overturn decisions (both standard and expedited) are binding on the Claims Administrator and Plan Administrator. If the decision of the IRO is that the services are eligible, the Claims Administrator authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment and/or approval of the service in the event of an overturn of the Internal Appeal. The Claims Administrator implements the IRO's decision within the time, if any, specified by the IRO.

OTHER COVERAGE

- Worker's Compensation
  Any benefits provided by Worker's Compensation are not duplicated by this Program.

- Medicare
  Any services paid or payable by Medicare when Medicare is:
  - Primary; or
  - Would have been primary if the Member had enrolled for Medicare, are not duplicated by this Program. For working Members over age 65, the primary payor will be determined in accordance with TEFRA or existing regulations regarding Medicare reimbursement.

NOTE: For more information regarding other coverage, see "Coordination Of Benefits" and "Subrogation".

INDEPENDENT CORPORATION

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

If the Member has questions about any of the information in this Benefit Booklet, or needs assistance at any time, please feel free to contact Customer Services by calling the telephone number shown on the Member ID Card.

IMPORTANT DEFINITIONS

The terms below have the following meaning when describing the benefits in this Benefit Booklet. They will be helpful to you (the Member) in fully understanding your benefits.

Accidental Injury
Injury to the body that is solely caused by an accident, and not by any other causes.

Accredited Educational Institution
- A publicly or privately operated academic institution of higher learning which:
- Provides recognized courses or a course of instruction.
- Confers any of the following, when a student completes the course of study:
  - A diploma;
  - A degree; or
  - Another recognized certification of completion.
- Is duly recognized, and declared as such, by the appropriate authority, as follows:
  - An authority of the state in which such institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to, colleges and universities; and technical or specialized schools.

Acupuncture
A therapeutic procedure performed by the insertion of one or more specially manufactured solid metallic needles into a specific location(s) on the body. The intent is to stimulate Acupuncture points, with or without subsequent manual manipulation.

Adverse Benefit Determination
A determination that includes any denial, reduction, or recission of health insurance coverage (when, in connection with the recission, there is an adverse effect on a particular benefit at that time). An Adverse Benefit Determination may be any of the following:
- A determination by the Plan or a utilization review entity on its behalf, that based on the information provided and upon application of utilization review, a request for a benefit under a health insurance policy does not meet the Plan's requirement for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provide or made, in whole or in part, for the benefit.
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by the Plan of a Member's eligibility for coverage under a health insurance policy or noncompliance with an administrative policy.
- A rescission of coverage determination by the Plan.

Administrative Services Only Agreement
The agreement for Administrative Services entered into between the Group and the Claims Administrator whereby the Group has requested that the Claims Administrator provide certain administrative, claims and managed care services in connection with this Program.

Alcohol Or Drug Abuse And Dependency
Any use of alcohol or other drugs which produces a pattern of pathological use that:
- Causes impairment in the way people relate to others; or
- Causes impairment in the way people function in their jobs or careers; or
- Produces a dependency that makes a person physically ill, when the alcohol or drug is taken away.

Alcohol Or Drug Abuse And Dependency Treatment Facility
A facility which is licensed by the Department of Health as an alcoholism or drug addiction treatment program that is primarily engaged in providing Detoxification and rehabilitation treatment for Alcohol Or Drug Abuse And Dependency.

Allowed Amount
This refers to the basis on which a Member's Deductibles, Coinsurance, Out-of-Pocket Maximum and benefits are calculated.
- For services provided by a Participating Facility Provider, the term "Allowed Amount" means the lesser of the actual charge and the amount paid by the Health Benefit Plan under a special pricing arrangement with Participating Facility Provider(s) unless the Participating Facility Provider's contractual arrangement with the Health Benefit Plan provides otherwise.
- For services provided by a Participating Professional Provider, "Allowed Amount" is the Health Benefit Plan’s fee schedule amount.
- For services provided by Participating Ancillary Service Providers, "Allowed Amount" means the amount that the Health Benefit Plan has negotiated with the Participating Ancillary Service Provider as total reimbursement for the Covered Services.

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

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

It is a Facility Provider which:
- Has an organized staff of Physicians;
- Is licensed as required; and
- Has been approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- Has been approved by the Accreditation Association for Ambulatory Health Care, Inc.; or
- Has been approved by the Claims Administrator.

It is also a Facility Provider which:
- Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
- Provides treatment, by or under the supervision of Physicians and nursing services, whenever the patient is in the facility;

- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

Ancillary Service Provider
An individual or entity that provides Covered Services, supplies or equipment such as, but not limited to:
- Home Infusion Therapy Services;
- Durable Medical Equipment; and
- Ambulance services.

Anesthesia
The process of giving the Member an approved drug or agent, in order to:
- Cause the Member's muscles to relax;
- Cause the Member to lose feeling; or
- Cause the Member to lose consciousness.

Annual Benefit Maximum
- The maximum amount of benefits provided to a Member in each Benefit Period.
- This amount is shown in the ***Schedule of Covered Services***.
- It does not include the amount the Member pays for Covered Services in the form of:
  - Copayments;
  - Coinsurance; and/or
  - Deductibles.

Appeal of An Administrative Denial
An appeal of any of the following types of Adverse Benefit Determinations:
- Prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy.
- Certain surprise medical bills received by a Member from an out-of-network provider.
- Rescission of coverage (except for failure to pay premiums or coverage contributions) that has not been resolved by the Plan and has been filed with the Pennsylvania Insurance Department.

This term does not include a Medical Necessity Appeal. It also does not include disputes or objections that were resolved by the HMO and did not result in the filing of an Appeal of an Administrative Denial (written or oral).

Artificial Insemination
The medical process of helping a Member become pregnant by:
- Taking sperms from a partner or donor;
- Inserting these sperms into a recipient's vagina or uterus;
- Taking the above steps, without there needing to be any physical contact between the recipient and donor.

The process includes simple sperm preparation, sperm washing and/or thawing.

Attention Deficit Disorder
A disease that makes a person have a hard time paying attention; be too impulsive; and be overly active.

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

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

An Autism Service Provider shall include a Behavioral Specialist.

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

Autism Spectrum Disorders Treatment Plan (ASD Treatment Plan)
A plan for the treatment of Autism Spectrum Disorders:

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

Away From Home Care Coordinator
The staff whose functions include assisting members with registering as a Guest Member for Guest Membership Benefits under the Away From Home Care Program.

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

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

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

Benefit Period
The specified period of time as shown in the ***Schedule of Covered Services*** within which the Member has to use Covered Services in order to be eligible for payment by their Claims Administrator. A charge shall be considered Incurred on the date the service or supply was provided to the Member.

Benefits Administrator
The person or entity designated by the Group to perform specific responsibilities, including but not limited to, administrative and reporting activities associated with this Program, such as assisting Members with their questions or notifying the Claims Administrator of new Members or enrollment changes (marital status, address, eligibility for Medicare). The Benefits Administrator is not the Health Benefit Plan.

Birth Center
A Facility Provider approved by the Claims Administrator which:
- Is primarily organized and staffed to provide maternity care;
- Is where a Member can go to receive maternity care and give birth;
- Is licensed as required in the state where it is situated; and
- Is under the supervision of a Physician or a licensed Certified Midwife.

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

Case Management
Comprehensive Case Management programs serve Members who have been diagnosed with an illness or injury that is complex, catastrophic, or chronic.

The objectives of Case Management are to:
- Make it easier for Members to get the service and care they need in an efficient way;
- Link the Member with appropriate health care or support services;
- Assist Providers in coordinating prescribed services;
- Monitor the quality of services delivered; and
- Improve Members' health outcomes.

Case Management supports Members and Providers by:
- Locating services;
- Coordinating services; and/or
- Evaluating services.

These steps are taken, across various levels and sites of care, for a Member who has been diagnosed with a complex, catastrophic or chronic illness and/or injury.

Certified Registered Nurse
Any one of the following types of nurses who are certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing:
- A certified registered nurse anesthetist;
- A certified registered nurse practitioner;
- A certified entreostomal therapy nurse;
- A certified community health nurse;
- A certified psychiatric mental health nurse; or
- A certified clinical nurse specialist

This excludes any registered professional nurses employed by:
- A health care facility; or
- An anesthesiology group.

Cognitive Rehabilitative Therapy
A medically prescribed, multidisciplinary approach that consists of tasks that:
- Establish new ways for a person to compensate for brain function that has been lost due to injury, trauma, stroke, or encephalopathy; or
- Reinforce or re-establish previously learned patterns of behavior.

It consists of a variety of therapy modalities which lessen and ease problems caused by deficits in:
- Attention;
- Visual processing;
- Language;
- Memory;
- Reasoning; and
- Problem solving.

Cognitive rehabilitation is performed by any of the following professionals, using a team approach:
- A Physician;
- A neuropsychologist;
- A Psychologist; as well as, a physical, occupational or speech therapist.

Coinsurance
A type of cost-sharing in which the Member assumes a percentage of Claims Administrator's fee schedule amount for Covered Services (such as 20 %). The Coinsurance percentage is listed in the ***Schedule of Covered Services*.**

Compendia
Compendia are reference documents used by the Claims Administrator to determine if a Prescription Drug should be covered. Compendia provide:
- Summaries of how drugs work;
- Information about which drugs are recommended to treat specific diseases; and
- The appropriate dosing schedule for each drug.

Over the years, some compendia have merged with other publications. The Claims Administrator only reviews current compendia when making coverage decisions.

Conditions For Departments (for Qualifying Clinical Trials)
The conditions described in this paragraph, for a study or investigation conducted by the Department of Veteran Affairs, Defense or Energy, are that the study or investigation has been reviewed and approved through a system of peer review that the Government determines:
- To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
- Assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.

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

Contraceptive Drugs
FDA approved drugs to be dispensed for the use of contraception. These include oral contraceptives, such as birth control pills, as well as injectable contraceptive drugs.

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

Coordination of Benefits (COB)
A provision that is intended to avoid claims payment delays and duplication of benefits, when a person is covered by two or more Group plans that provide benefits or services for medical, dental or other care or treatment.

- It avoids claims payment delays by establishing an order in which plans pay their claims, and by providing the authority for the orderly transfer of information needed to pay claims promptly.
- It avoids duplication of benefits by permitting a reduction of the benefits of a plan when, by the Rules established by this provision, that plan does not have to pay benefits first.
- This provision does not apply to:
  - Student accident plans paying $100 per day or less; or
  - Group hospital indemnity plans paying $100 per day or less.

Copayment
A specified dollar amount that is applied to a specific Covered Service for which the Member is responsible per Covered Service. Copayments, if any, are identified in the ***Schedule of Covered Services***.

Covered Service
A service or supply specified in this Benefit Booklet for which benefits will be provided by the Claims Administrator.

Custodial Care (Domiciliary Care)
Care provided primarily for Maintenance of the patient or care which is designed essentially:

- To assist the patient in meeting their activities of daily living; and
- Which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Custodial Care includes help in tasks which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

Such tasks include, but are not limited to:

- Walking;
- Bathing;
- Dressing;
- Feeding;
- Preparation of special diets; and
- Supervision over self-administration of medications

Day Rehabilitation Program
A level of Outpatient Care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week.
The Member returns home:
- Each evening; and
- For the entire weekend.

Therapies provided may include a combination of therapies, such as:
- Physical Therapy;
- Occupational Therapy; and
- Speech Therapy.

Other medical services such as:
- Nursing services;
- Psychological therapy; and
- Case Management services.

Day Rehabilitation sessions also include a combination of:
- One-to-one therapy; and
- Group therapy.

Decision Support
Services that help members make well-informed decisions about health care and support their ability to follow their Participating Provider's treatment plan. Some examples of support services are:
- Major treatment choices; and
- Every day health choices.

Dependent
An individual, who relies on the Member for some level of aid and support and:
- Who resides in the Service Area;
- For whom Medicare is not primary pursuant to any federal or state regulation, law or ruling;
- Who is enrolled under the Claims Administrator coverage; and
- Who meets all of the eligibility requirements established by the Group and the Health Benefit Plan as described in the Eligibility subsection of the ***General Information*** section of this Benefit Booklet.

Designated Provider
A Participating Provider with whom the Claims Administrator has contracted the following Outpatient services:
- Certain rehabilitation Therapy Services (other than Speech Therapy);
- Diagnostic radiology services for Members age five or older; or
- Laboratory and pathology tests.

The Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

Detoxification
The process by which a person who is alcohol or drug intoxicated, or alcohol or drug dependent, is assisted under the following circumstances:

- In a state licensed Facility Provider; or
- In the case of opiates, by an appropriately licensed Behavioral Health/Alcohol Or Drug Abuse And Dependency provider, in an ambulatory (Outpatient) setting.

This treatment process will occur through the period of time necessary to eliminate, by metabolic or other means, any or each of the following problems:

- The intoxicating alcohol or drug;
- Alcohol or drug dependency factors; or
- Alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

Disease Management
An approved program designed to identify and help people, who have a particular chronic disease, to stay as healthy as possible

- Disease Management programs use a population-based approach to:
  - Identify Members who have or are at risk for a particular chronic medical condition;
  - Intervene with specific programs of care; and
  - Measure and improve outcomes.
- Disease Management programs use evidence-based guidelines to:
  - Educate and support Members and PCP's and Participating Professional Providers;
  - Matching interventions to Members with greatest opportunity for improved clinical or functional outcomes.
- To assist Members with chronic disease(s), Disease Management programs may employ:
  - Education;
  - Provider feedback and support statistics;
  - Compliance monitoring and reporting; and/or
  - Preventive medicine.
- Disease Management interventions are intended to both:
  - Improve delivery of services in various active stages of the disease process; as well as to reduce/prevent relapse or acute exacerbation of the condition.

Domestic Partner (Domestic Partnership)
An individual of a Domestic Partnership consisting of two people **"**of the same sex" each of whom:

- Is unmarried, at least eighteen (18) years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other partner by adoption or blood;
- Is the sole Domestic Partner of the other partner, with whom they have a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six (6) months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and
- Demonstrates financial interdependence by submission of proof of three (3) or more of the following documents:
  - A Domestic Partnership agreement;

- A joint mortgage or lease;
- A designation of one of the partners as beneficiary in the other partner's will;
- A durable property and health care powers of attorney;
- A joint title to an automobile, or joint bank account or credit account; or
- Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

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

Durable Medical Equipment (DME)
Equipment that meets the following criteria:
- It is durable and can withstand repeated use;
- It is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;
- It generally is not useful to a person in the absence of an illness or injury; and
- It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to:
- Diabetic supplies;
- Canes;
- Crutches;
- Walkers;
- Commode chairs;
- Home oxygen equipment;
- Hospital beds;
- Traction equipment; and
- Wheelchairs.

Effective Date
The date on which coverage for a Member begins under the Program. All coverage begins at 12:01 a.m. on the date reflected on the records of the Claims Administrator.

Emergency Services (Emergency)
Any health care services, including services for Mental Illness, provided to a Member after the sudden onset of a medical condition. The condition manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the Member or with respect to a pregnant Member, the health of the pregnant Member or unborn child, in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

Employee
An individual of the Group contracting with the Claims Administrator and:
- Who meets the eligibility requirements for enrollment;
- Who, at enrollment, is specified as meeting the eligibility requirements; and
- In whose name the Identification Card is issued.

Enrollment/Change Form
The properly completed, written request for enrollment for Program membership:
- Submitted in a format provided by the Claims Administrator; and
- Together with any amendments or modifications to that written request.

Enteral Nutrition (Tube Feeding)
The provision of nutritional requirements into the alimentary tract.

Essential Health Benefits
A set of health care service categories that must be covered by certain plans in accordance with the Affordable Care Act. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/Investigative Services
A drug, biological product, device, medical treatment or procedure, or diagnostic test, which meets any of the following criteria:
- Is the subject of ongoing Clinical Trials;
- Is the research, experimental, study or investigational arm of an on-going Clinical Trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
- Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

Any drug, biological product, device, medical treatment or procedure, or diagnostic procedure, is not considered Experimental/Investigative if it meets all of the criteria listed below:
- When required the drug, biological product, device, medical treatment or procedure, or diagnostic test, must have final approval from the appropriate governmental regulatory bodies (e.g. FDA).
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test, meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- Reliable Evidence demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic tests, leads to measurable improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the drug, biological product, device, medical treatment or procedure, or diagnostic test, is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the paragraph above, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, device, medical treatment or procedure, or diagnostic test, is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

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

Facility Provider
An institution or entity licensed, where required, to provide care.

Such facilities include:
- Ambulatory Surgical Facility;
- Birth Center;
- Free Standing Dialysis Facility;
- Free Standing Ambulatory Care Facility;
- Home Health Care Agency;
- Hospice;
- Hospital;
- Non-Hospital Facility;
- Psychiatric Hospital;
- Rehabilitation Hospital;
- Residential Treatment Facility;
- Short Procedure Unit;
- Skilled Nursing Facility

Such facilities include:
- Ambulatory Surgical Facility;
- Birth Center;
- Free Standing Dialysis Facility;
- Free Standing Ambulatory Care Facility;
- Home Health Care Agency;
- Hospice;
- Hospital;
- Rehabilitation Hospital;
- Short Procedure Unit;
- Skilled Nursing Facility.

Follow-Up Care
Care scheduled for Medically Necessary follow-up visits that occur while the Member is away from home.
- Follow-Up Care is provided only for urgent ongoing treatment of an illness or injury that originates while the Member is still at home. An example is Dialysis.
- Follow-Up Care must be Preapproved by the Member's Primary Care Physician prior to traveling.

This service is available through the BlueCard Program for temporary absences (less than 90 consecutive days) from Keystone's Service Area.

Free Standing Ambulatory Care Facility
A Facility Provider, other than a Hospital, that provides treatment or services on an Outpatient or partial basis.

In addition, the facility:

- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician.
- Is licensed by the state in which it is located and be accredited by the appropriate regulatory body.

Free Standing Dialysis Facility
A Facility Provider that provides dialysis services for people who have serious kidney disease.

In addition, the facility:

- Is primarily engaged in providing dialysis treatment, Maintenance or training to patients on an Outpatient or home care basis.
- Is licensed or approved by the appropriate governmental agency; and
- Is approved by the Claims Administrator.

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

Group
The entity which established, sponsors, and/or maintains a welfare benefit plan for the purpose of providing health insurance benefits to plan Members or their beneficiaries, and which, on behalf of the welfare benefit plan, has agreed to remit payments to the Claims Administrator and to receive, on behalf of the enrolled Members, any information from the Claims Administrator related to the benefits provided to enrolled Members pursuant to the terms of the Administrative Services Only Agreement.

Guest Member
A Member who has a pre-authorized Guest Member registration in a Host HMO Service Area for a defined period of time.

After that period of time has expired the Member must again meet the eligibility requirements for Guest Membership Benefits, under the Away From Home Care Program and re-enroll within thirty (30) days before the Guest Membership Benefit period ends to be covered for those benefits.

A Subscriber's eligible Dependent may register as a 'Student Guest Member.

- The Dependent must be a student residing outside the Keystone's Service Area and inside a Host HMO Service Area.
- The Dependent student must not be residing with the Subscriber and must be residing in a Host HMO Service Area.

Guest Membership (Guest Membership Program)
A program that provides Guest Membership Benefits to Members while traveling out of the Keystone's Service Area for a period of at least 90 consecutive days.

Guest Membership Overview

- Guest Membership Benefits provide coverage for a wide range of health care services.

- The Guest Membership Program offers portable HMO coverage to Members of plans contracting in the Keystone's network.
- Services provided under the Guest Membership Program are coordinated by the Guest Membership Coordinator.
- Guest Membership is available for a limited period of time.

The Guest Membership Coordinator will confirm the period for which a Member is registered as a Guest Member.

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

Guest Membership Coordinator
The staff that assists Members with registration for Guest Membership, and provides other assistance to Members while Guest Members.

Hearing Aid
A device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of:
- A microphone to pick up sound;
- An amplifier to increase the sound;
- A receiver to transmit the sound to the ear; and
- A battery for power.

A Hearing Aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a Hearing Aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles:
- Behind-The-Ear;
- In-The-Ear;
- In-The-Canal;
- Completely-In-The-Canal; or
- Implantable (Can Be Partial or Complete).

A Hearing Aid is not a cochlear implant.

Home
For purposes of the Home Health Care and Homebound Covered Services only, this is the place where the Member lives.

This place may be:
- A private residence/domicile;

- An assisted living facility;
- A long-term care facility; or
- A Skilled Nursing Facility at a custodial level of care.

Home Health Care Provider
A licensed Provider that provides home health care Covered Services to Members.
Services are provided:
- On an intermittent basis in the Member's Home;
- In accordance with an approved home health care Plan Of Treatment; and
- Based on an agreement entered into with the Claims Administrator.

Homebound
Being unable to safely leave Home due to severe restrictions on the Member's mobility.

A person can be considered Homebound when leaving Home would do the following:
- Involve a considerable effort by the Member; and
- Leave the Member unable to use transportation, without another's assistance.

The following individuals will NOT automatically be considered Homebound, but must meet both requirements above:
- A child
- An unlicensed driver; or
- An individual who cannot drive.

Hospice
A Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals.

The Hospice must be:
- Certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and
- Appropriately licensed in the state where it is located.

Hospice Provider
Licensed Provider that is primarily engaged in providing care to terminally ill people whose estimated survival is six months or less.

Hospice Care is primarily comfort care and includes:
- Relief of pain;
- Management of symptoms; and
- Supportive services that will help the Member cope with a terminal illness rather than cure it.

Covered Services to be provided by the Hospice Provider include Home Hospice and/or Inpatient Hospice services that have been referred by the Member's Primary Care Physician and Preapproved by the Claims Administrator.

Hospital
An approved facility that provides Inpatient, as well as Outpatient Care, and that meet the requirements listed below.

The term Hospital specifically refers to a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations; and/or by the American Osteopathic Hospital Association or by the Health Benefits Plan, and which meets the following requirements:

- Is a duly licensed institution;
- Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- Has organized departments of medicine;
- Provides 24-hour nursing service by or under the supervision of Registered Nurses;

- Is not, other than incidentally, any of the following:
  - Skilled Nursing Facility;
  - Nursing home;
  - School;
  - Custodial Care home;
  - Health resort;
  - Spa or sanitarium;
  - Place for rest;
  - Place for aged;
  - Place for treatment of Mental Illness;
  - Place for treatment of Alcohol or Drug Abuse;
  - Place for provision of rehabilitation care;
  - A place for treatment of pulmonary tuberculosis;
  - A place for provision of Hospice care.

Hospital-Based Provider
A Physician who provides Medically Necessary services in a Hospital or other Participating Facility Provider and meets the requirements listed below:

- The Medically Necessary services must be supplemental to the primary care being provided in the Hospital or Participating Facility Provider;
- The Medically Necessary services must be those for which the Member has limited or no control of the selection of such Physician;
- Hospital-Based Providers include Physicians in the specialties of:
  - Radiology;
  - Anesthesiology;
  - Pathology; and/or
  - Other specialties, as determined by the Claims Administrator.

When these Physicians provide services other than in the Hospital or other Participating Facility, they are not considered Hospital-Based Providers.

Hospital Services
Health care services that (except as limited or excluded herein) are all of the following:

- Are acute-care Covered Services, provided in a Hospital, which are Referred by the Member's Primary Care Physician or provided by the Member's Referred Specialist and Preapproved by the Claims Administrator where required; and are listed in the Description of Covered Services.

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

Host HMO Service Area
Host HMO's approved geographical area within which the Host HMO is approved to provide access to Covered Services.

Identification Card (ID Card)
The currently effective card issued to the Member by the Claims Administrator which must be presented when a Covered Service is requested.

Immediate Family
The Employee's:
- Spouse;
- Parent;
- Child;
- Brother,
- Sister;
- Persons who ordinarily reside in the household of the Employee.

Immunizations
Medication that helps protect a person from certain infections. All Immunizations must conform to the standards set by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.

Coverage for routine Immunizations is provided for adult and pediatric Members (limited to Members under 21 years of age).

For routine immunizations, the Claims Administrator provides coverage for
- The administration of the Immunization, and
- The agent used for Immunization.

The Claims Administrator does not provide coverage for:
- Employment-related Immunizations;
- Travel-related Immunizations; and
- Immunizations that are not recommended by the ACIP.

ACIP Immunization schedules can be found in the Preventive Schedule document.

Incurred
A charge shall be considered Incurred (acquired) on the date a Member receives the service or supply for which the charge is made.

Independent Clinical Laboratory
A laboratory that performs clinical pathology procedure and that is not affiliated or associated with a:
- Hospital;
- Physician; or
- Facility Provider.

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

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

Inpatient Admission (Inpatient)
The actual entry of a Member, who is to receive Inpatient services as a registered bed patient, and for whom a room and board charge is made, into any of the following:
- Hospital;
- Extended care facility; or
- Facility Provider.

The Inpatient Admission shall continue until such time as the Member is actually discharged from the facility.

Inpatient Care
Treatment received as a bed patient in a:
- Hospital
- Rehabilitation Hospital
- Skilled Nursing Facility; or
- Participating Facility Provider that is a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

Intensive Outpatient Program
A planned, structured program that coordinates and uses the services of various health professionals, to treat patients in crisis who suffer from:
- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency.

Intensive Outpatient Program treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until they are able to transition to less intensive Outpatient treatment, as required.

Keystone Health Plan East, Inc. ("Keystone" or "The Health Benefit Plan")
A health maintenance organization providing access to comprehensive health care to Members.

Licensed Clinical Social Worker
A social worker who:
- Has graduated from a school accredited by the Council on Social Work Education with a Doctoral or Master's Degree; and
- Is licensed by the appropriate state authority.

Licensed Practical Nurse (LPN)
A nurse who:
- Has graduated from a formal practical or nursing education program; and
- Is licensed by the appropriate state authority.

Life-Threatening Disease Or Condition (for Qualifying Clinical Trials)
Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Limitations
The maximum number of Covered Services that are eligible for coverage.
- The maximum number of Covered Services can be measured as:
  - Hours;
  - Visits;
  - Days; or the
  - Dollar amount.
- Limitations may vary depending on the type of program and Covered Services provided.
- Limitations, if any, are identified in the ***Schedule of Covered Services***.

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

The Limiting Age for Dependents is: 26

Maintenance
A continuation of the Member's care and management when:
- The maximum therapeutic value of a Medically Necessary treatment plan has been achieved;
- No additional functional improvement is apparent or expected to occur;
- The provision of Covered Services for a condition ceases to be of therapeutic value; and
- It is no longer Medically Necessary.

This includes Maintenance services that seek to:
- Prevent disease;
- Promote health; and
- Prolong and enhance the quality of life.

Masters Prepared Therapist
A therapist who:
- Holds a Master's Degree in an acceptable human services-related field of study;
- Is licensed as a therapist at an independent practice level; and
- Is licensed by the appropriate state authority to provide therapeutic services for the treatment of Mental health care and Serious Mental Illness health care.

Medical Care
Services rendered by a Participating Professional Provider for the treatment of an illness or injury. These are services that must be rendered within the scope of their license.

Medical Director
A Physician designated by the Claims Administrator to:
- Design and implement quality assurance programs; and
- Monitor utilization of health services by Members.

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

Medical Policy
Medical Policy is used to determine whether Covered Services are Medically Necessary.
Medical Policy is developed based on various sources including, but not limited to:
- Peer-reviewed scientific literature published in journals and textbooks; and
- Guidelines put forth by governmental agencies; and
- Respected professional organizations; and
- Recommendations of experts in the relevant medical specialty.

Medical Necessity Appeal
An appeal of an Adverse Benefit Determination that the request for a benefit under a health insurance policy does not meet the Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational. This includes an Adverse Benefit Determination that does any of the following: (i) disapproves full or partial payment for a requested health care service; (ii) approves the provision of a requested health care service for a lesser scope or duration than requested; or (iii) disapproves payment of the provision of a requested health care service but approves payment for the provision of an alternative health care service. The term does not include an Appeal of an Administrative Denial. It also does not include disputes or objections regarding Medical Necessity that were resolved by the HMO and did not result in the filing of a Medical Necessity Appeal (written or oral).

Medical Screening Evaluation
An examination and evaluation within the capability of the Hospital's emergency department, including ancillary services routinely available to the emergency department, performed by qualified personnel.

Medical Technology Assessment
The review and evaluation of available clinical and scientific information from expert sources.

These sources include, and are not limited to:
- Publications from government agencies;

- Peer-reviewed journals;
- Professional guidelines;
- Regional and national experts;
- Clinical trials; and
- Manufacturers' literature.

The Claims Administrator uses the technology assessment process to assure that new drugs, procedures or devices are safe and effective before approving them as a Covered Service.

When new technology becomes available or at the request of a practitioner or Member:
- The Claims Administrator researches all scientific information available from these expert sources.
- Following this analysis, the Claims Administrator:
  - Makes a decision about when a new drug, procedure or device has been proven to be safe and effective; and
  - Uses this information to determine when an item becomes a Covered Service.

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

Medically Necessary (Medical Necessity)
Shall mean:
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of:
  - Preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient, that are:
  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
  - Not primarily for the convenience of the patient, Physician, or other health care provider;
  - Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease; and
  - Furnished in the most appropriate and cost-effective setting (site of care) that is appropriate to the member's medical needs and condition, based on the member's current medical condition and any required monitoring or additional services that may coincide with the delivery of this service.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on:
  - Credible scientific evidence, published in peer-reviewed medical literature that is generally recognized by the relevant medical community, Physician Specialty Society recommendations;
  - The views of Physicians practicing in relevant clinical areas; and
  - Any other relevant factors.

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

Member
A Subscriber or Dependent who meets the eligibility requirements for enrollment by the Group.

A Member does NOT mean any person who is eligible for Medicare, except as specifically stated in this Benefit Booklet.

Mental Illness
Any of various conditions, wherein mental treatment is provided by a qualified Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

- These various conditions must be categorized as mental disorders by the most current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM).
- For purposes of this Program, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness or Autism Spectrum Disorders.
- The benefit limits for Mental Illness, Serious Mental Illness, and Autism Spectrum Disorders are separate and not cumulative.

Non-Hospital Facility
A Facility Provider, licensed by the Department of Health for the care or treatment of Members diagnosed with Alcohol Or Drug Abuse And Dependency. This does NOT include transitional living facilities.

Non-Hospital Facilities shall include, but not be limited to the following, for Partial Hospitalization Programs:

- Residential Treatment Facilities; and
- Freestanding Ambulatory Care Facilities**.**

Non-Participating Provider
A Facility Provider, Professional Provider, Ancillary Service Provider that is NOT a member of the Claims Administrator’s network.

Nutritional Formula
Liquid nutritional products which are formulated to supplement or replace normal food products.

Office Visits
Covered Services provided in the Physician's office and performed by or under the direction of:

- The Primary Care Physician; or
- A Participating Professional Provider.

Out-Of-Pocket Maximum
The maximum dollar amount that a Member pays for Covered Services under this Benefit Booklet in each Benefit Period as shown in the Schedule of Covered Services. The Out-of-Pocket Maximum includes Copayments, Coinsurance, and Deductibles, when applicable, for Essential Health Benefits. It does not include any amounts above the Allowed Amount for a specific Provider, or the amount for any services not covered under this Benefit Booklet.

Outpatient Care (or Outpatient)
Medical, nursing, counseling or therapeutic treatment provided to a Member who does not require an overnight stay in a Hospital or other Inpatient Facility.

Outpatient Diabetic Education Program
An Outpatient Diabetic Education Program, provided by a Participating Professional Provider that has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

Outpatient Mental Health Care
Outpatient Serious Mental Illness Health Care
Outpatient Alcohol Or Drug Abuse And Dependency Treatment (Outpatient Treatment)
The provision of medical, nursing, counseling or therapeutic Covered Services:

- On a planned and regularly scheduled basis;
- At a Participating Facility Provider licensed by the Department of Health as:
  - An Alcohol Or Drug Abuse And Dependency treatment program; or
  - Any other mental health or Serious Mental Illness therapeutic modality, designed for a patient or Member who does not require care as an Inpatient.
- Outpatient Treatment includes: Care provided under a Partial Hospitalization program or an Intensive Outpatient Program. Each Outpatient visit or session is subject to:
  - The applicable Outpatient Mental Health Care Visits/Sessions cost sharing;
  - Outpatient Serious Mental Illness Health Care Visits/Sessions cost sharing; or
  - Outpatient Alcohol Or Drug Abuse And Dependency Treatment Visits/Sessions cost sharing.

Partial Hospitalization
Medical, nursing, counseling or therapeutic services that are:

- Provided on a planned and regularly scheduled basis in a Hospital or Facility Provider,
- Designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment (Intensive Outpatient Program or Outpatient Office Visit) but who does not require Inpatient confinement.

Participating Facility Provider
A Facility Provider that is a member of the Claims Administrator's network.

Participating Professional Provider
A Professional Provider who is a member of the Claims Administrator's network.

Participating Provider
A Facility Provider, Professional Provider, or Ancillary Services Provider with whom the Claims Administrator has contracted directly or indirectly and, where applicable, is Medicare certified to render Covered Services. This includes, but is not limited to:

- Primary Care Physician (PCP)

  A Participating Provider selected by a Member who is responsible for providing all primary care Covered Services and for authorizing and coordinating all covered Medical Care, including Referrals for Specialist Services. The Member may designate a Participating Obstetrician and Gynecologist as their PCP. For children, the Member may designate a pediatrician as the PCP.

- Referred Specialist
  A Provider who provides Covered Specialist Services within their specialty and upon Referral from a Primary Care Physician. In the event there is no Participating Provider to provide the specialty or subspecialty services, Referral to a Non-Participating Provider will be arranged by the Member's Primary Care Physician with Preapproval by the Claims Administrator. See ***Access To Primary, Specialist, and Hospital Care*** in the ***General Information*** section for procedures for obtaining Preapproval for use of a Non-Participating Provider.

  A Referred Specialist also includes Participating Professional Providers that provide the following designated services without a Referral:
  - Care from a Participating obstetrical/gynecological specialist; and
  - Dialysis.

  For the following Outpatient services, the Referred Specialist is the Member's Primary Care Physician's Designated Provider:
  - Certain rehabilitation Therapy Services (other than Speech Therapy);
  - Certain diagnostic radiology services for Members are age five or older; or
  - Laboratory and pathology tests. The Member's Primary Care Physician will provide a Referral to the Designated Provider for these services.

- Obstetricians and Gynecologists
  A Participating Provider selected by a Member who provides Covered Services without a Referral.

  Participating obstetricians and gynecologists have the same responsibilities as Referred Specialists. For example, seeking Preapproval for certain services.

  Similarly, just as the Member has the right to designate a Referred Specialist as the Member's PCP, the Member may designate a participating obstetrician or gynecologist as the Member's PCP.

- Participating Hospital
  A Hospital that has contracted with the Claims Administrator to provide Covered Services to Members.

- Durable Medical Equipment (DME) Provider
  A Participating Provider of Durable Medical Equipment that has contracted with the Claims Administrator to provide Covered Supplies to Members.

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

- Hospice Provider
  A licensed Participating Provider that is primarily engaged in providing pain relief, symptom management, and supportive services to a terminally ill Member with a medical prognosis of six months or less.

Pervasive Developmental Disorders (PDD)
Disorders characterized by severe and pervasive impairment in several areas of development:
- Reciprocal social interaction skills;
- Communication skills; or
- The presence of stereotyped behavior, interests and activities.

Examples are:
- Asperger's syndrome; and
- Childhood disintegrative disorder.

Pharmacist
An individual, who is duly licensed as a Pharmacist by:
- The State Board of Pharmacy; or
- Other governing body having jurisdiction.

An individual, who also is:
- Employed by a pharmacy; or
- Associated with a pharmacy.

Pharmacy and Therapeutics Committee
A group composed of health care professionals with recognized knowledge and expertise in: Clinically appropriate prescribing, dispensing and monitoring of Outpatient drugs or drug use review, evaluation and intervention.

The membership of the committee consists of at least two-thirds licensed and actively practicing Physicians; and Pharmacists and shall consist of at least one Pharmacist.

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

Plan Administrator
The person or entity that has discretionary authority or responsibility to control and manage the operation and administration of the Program, as provided in the documents establishing the Program, in accordance with Employee Retirement Income Security Act (ERISA). The Claims Administrator is not the Plan Administrator.

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

Preapproved (Preapproval) (Medical)
The approval which the Primary Care Physician or Participating Professional Provider must obtain from the Claims Administrator to confirm the Claims Administrator's coverage for certain Covered Services. Such approval must be obtained prior to providing Members with Covered Services or Referrals. Approval will be given by the appropriate Claims Administrator staff, under the supervision of the Medical Director. If the Primary Care Physician or Participating Professional Provider is required to obtain a Preapproval, and provides Covered Services or Referrals without obtaining such Preapproval, the Member will not be responsible for payment. Preapproval is not required for a maternity Inpatient Admission. To access a complete list of services that require Preapproval, log onto www.ibx.com/preapproval, or the Member can call Customer Service at the phone number listed on the Member's ID card to have the list mailed to the Member.

Prenotification (Prenotify)
The requirement that a Member provide prior notice to the Claims Administrator that proposed services, such as maternity care, are scheduled to be performed.
- No penalty will be applied for failure to comply with this requirement.
- Payment for services depends on whether the Member and the category of service are covered under this Program.
- To Prenotify, the Member should call the telephone number on the ID card, prior to obtaining the proposed service.

Prescribe or Prescribed
To write or give a Prescription Order.

Prescription Drug
A Legend Drug or Controlled Substance, which:
- Has been approved by the Food and Drug Administration (FDA) for a specific use; and
- Can, under federal or state law, be dispensed only pursuant to a Prescription Order.

To find out if the Member's Prescription Drug has been approved by the Claims Administrator:
- Call Customer Service at the telephone number shown on the Member's ID Card; or
- Ask the Member's Primary Care Physician to call Provider Services.

Prescription Order
The authorization for:
- A Prescription Drug, or
- Services or supplies prescribed for the diagnosis or treatment of an illness, which are issued by a Primary Care Physician or Participating Provider who is duly licensed to make such an authorization in the ordinary course of their professional practice.

Prescription Order Or Refill Maximum
The maximum dollar amount a Member will pay toward Covered Drugs or Supplies per Prescription Drug Order or Refill. The maximum dollar amount that applies is shown in the ***Schedule Of Covered Services***.

Private Duty Nursing
Private Duty Nursing is Medically Necessary, complex skilled nursing care provided in the Member's private residence by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). It provides continuous monitoring and observation of a Member who requires frequent skilled nursing care on an hourly basis. Private Duty Nursing must be ordered by a Professional Provider who is involved in the oversight of the Member's care, in accordance with the Provider's scope of practice.

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

- Audiologist;
- Autism Service Provider;
- Behavioral Specialist;
- Certified Registered Nurse;
- Chiropractor;
- Dentist;
- Independent Clinical Laboratory;
- Licensed Clinical Social Worker;
- Master's Prepared Therapist;
- Certified Midwife;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- Podiatrist;
- Psychologist;
- Registered Dietitian;
- Speech-language Pathologist; and
- Teacher of the hearing impaired

Program
The benefit plan provided by the Group through an arrangement with the Claims Administrator.

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

Provider
Any health care institution, practitioner, or group of practitioners that are licensed to render health care services including, but not limited to:
- Physician;
- Group of Physicians;
- Allied health professional;
- Skilled Nursing Facility;
- Rehabilitation Hospital;
- Birthing facility; or

- Certified Midwife;
- Hospital;
- Home Health Care Provider

In addition, for Mental Health Care and Serious Mental Illness services only, the following are authorized to render mental health care services and are also considered Providers:
- Licensed Clinical Social Worker; and
- A Masters Prepared Therapist.

Psychiatric Hospital
A Facility Provider, approved by the Claims Administrator, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness.
- Such services are provided by or under the supervision of an organized staff of Physicians.
- Continuous nursing services are provided under the supervision of a Registered Nurse.

Psychologist
A Psychologist who is:
- Licensed in the state in which they practice; or
- Otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

Qualifying Clinical Trial
A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:
- Federally funded trials: The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - The National Institutes of Health (NIH);
  - The Centers for Disease Control and Prevention (CDC);
  - The Agency for Healthcare Research and Quality (AHRQ);
  - The Centers for Medicare and Medicaid Services (CMS);
  - Cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - Any of the following, if the Conditions For Departments are met:
    - The Department of Veterans Affairs (VA);
    - The Department of Defense (DOD); or
    - The Department of Energy (DOE).
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

Qualified Individual (for Clinical Trials)
A Member who meets the following conditions:
- The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition; and

- Either:
  - The referring health care professional is a health care provider participating in the clinical trial and has concluded that the Member's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or
  - The Member provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Member meeting the conditions described above.

Referred (Referral)
Electronic documentation from the Member's Primary Care Physician that authorizes Covered Services to be rendered by:
- A Participating Provider or group of Providers; or
- The Provider specifically named on the Referral.

Referred care includes all services provided by a Referred Specialist.

Referrals to Non-Participating Providers must be preapproved by the Claims Administrator.

A Referral:
- Must be issued to the Member prior to receiving Covered Services; and
- Is valid for 90 days from the date of issue for an enrolled Member.

For procedures for obtaining Preapproval for use of a Non- Participating Provider see Access To Primary, Specialist And Hospital Care in the ***General Information*** section.

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

Registered Nurse (R.N.)
A nurse who:
- Has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program); and
- Is licensed by the appropriate state authority.

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

Reliable Evidence
Peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

Residential Treatment Facility
A Facility Provider licensed and approved by the appropriate government agency and approved by the Claims Administrator, which provides treatment for:
- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency to partial, Outpatient or live-in patients who do not require acute Medical Care.

Respite Care
Respite care is temporary care that relieves the family and/or caretaker(s) of a Member who is receiving Hospice care. Respite care generally takes place in a Skilled Nursing Facility (SNF).

Retail Clinics
Retail Clinics are staffed by certified nurse practitioners trained to diagnose, treat and write prescriptions when clinically appropriate.
- Services are available to treat basic medical needs for Urgent Care.
- Examples of needs are:
  - Sore throat;
  - Ear, eye or sinus infection;
  - Allergies;
  - Minor burns;
  - Skin infections or rashes; and
  - Pregnancy testing

Rider
A legal document which modifies the protection of the Administrative Services Only Agreement and this Benefit Booklet either by:
- Expanding, decreasing or defining benefits; or
- Adding or excluding certain conditions from coverage under the Contract and this Benefit Booklet.

Routine Patient Costs Associated With Qualifying Clinical Trials
Routine patient costs include all items and services consistent with the coverage provided under this Program that is typically covered for a Qualified Individual who is not enrolled in a clinical trial.

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

Self-Administered Prescription Drug
A Prescription Drug that can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required. Examples of Self-Administered Prescription Drugs include, but are not limited to:
- Oral drugs;
- Self-Injectable Drugs;
- Inhaled drugs; and
- Topical drugs.

Self-Injectable Prescription Drug (Self-Injectable Drug)
A Prescription Drug that:
- Is introduced into a muscle or under the skin by means of a syringe and needle; and
- Can be administered safely and effectively by the patient or caregiver without medical supervision, regardless of whether initial medical supervision and/or instruction is required.

Serious Mental Illness
Means any of the following biologically based Mental Illnesses: As defined by the American Psychiatric Association, in the most recent edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM):
- Schizophrenia;
- Bipolar disorder;
- Obsessive-compulsive disorder;
- Major depressive disorder;
- Panic disorder;
- Anorexia nervosa;
- Bulimia nervosa;
- Schizo-affective disorder;
- Delusional disorder; and
- Any other Mental Illness that is considered to be "Serious Mental Illness" by law**]**

Benefits are provided for diagnosis and treatment of these conditions when:
- Determined to be Medically Necessary and
- Provided by a Behavioral Health/Alcohol Or Drug Abuse And Dependency Provider.

Covered Services may be provided on an Outpatient or Inpatient basis.

Service Area
The geographical area within which the Claims Administrator is approved to provide access to Covered Services.

Severe Systemic Protein Allergy
Means allergic symptoms to ingested proteins of sufficient magnitude to cause:
- Weight loss or failure to gain weight;
- Skin rash;
- Respiratory symptoms; and
- Gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

Short Procedure Unit
A unit which is approved by the Claims Administrator and which is designed to handle the following kinds of procedures on an Outpatient basis:
- Lengthy diagnostic procedures; or
- Minor surgical procedures.

In the absence of a Short Procedure Unit these are procedures which would otherwise have resulted in an Inpatient Admission.

Skilled Nursing Facility
An institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol Or Drug Abuse And Dependency.

It is also an institution which:
- Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- Is otherwise acceptable to the Claims Administrator

Sleep Studies
Refers to the continuous and simultaneous monitoring and recording of various physiologic and pathophysiologic sleep parameters. Sleep tests are performed to:
- Diagnose sleep disorders (For example: narcolepsy, sleep apnea, parasomnias);
- Initiate treatment for a sleep disorder; and/or
- Evaluate an individual's response to therapies such as continuous positive airway pressure (CPAP) or bi-level positive airway pressure device (BPAP).

Sound Natural Teeth
Teeth that are:
- Stable;
- Functional;
- Free from decay and advanced periodontal disease;
- In good repair at the time of the Accidental Injury/trauma; and
- Are not man-made.

Specialist Services
All Professional Provider services providing Medical Care or mental health/Psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Drug
A medication that meets certain criteria including, but not limited to:
- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a healthcare provider to administer the drug.
- Complex storage and/or shipping requirements are necessary to maintain the drug's stability.
- The drug requires comprehensive patient monitoring and education by a healthcare Provider regarding safety, side effects, and compliance.
- Access to the drug may be limited.
- Some Generic Drugs are included in this category and are subject to the Specialty Drug cost-sharing.

The Health Benefit Plan reserves the right to determine which Specialty Drug vendors and/or healthcare providers can dispense or administer certain Specialty Drugs.

Standard Injectable Drug
A medication that is either injectable or infusible:
- But is not defined by the Claims Administrator to be a Self-Administered Prescription Drug or a Specialty Drug.

Standard Injectable Drugs include, but are not limited to:
- Allergy injections and extractions; and
- Injectable medications such as antibiotics and steroid injections that are administered by a Participating Professional Provider.

Standing Referral (Standing Referred)
Electronic documentation from the Claims Administrator that authorizes Covered Services for: A life-threatening, degenerative or disabling disease or condition.
- The Covered Services will be rendered by the Referred Specialist named in the electronic documentation.
  - The Referred Specialist will have clinical expertise in treating the disease or condition.
- A Standing Referral must be issued to the Member prior to receiving Covered Services.
  - The Member, the Primary Care Physician and the Referred Specialist will be notified in writing of the length of time that the Standing Referral is valid.
  - Standing Referred Care includes all primary and Specialist Services provided by that Referred Specialist.

Subscriber
The person who is eligible and is enrolled for coverage.

Surgery
The performance of generally accepted operative and cutting procedures including:
- Specialized instrumentations;
- Endoscopic examinations; and
- Other invasive procedures.

Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care.

Treatment of burns, fractures and dislocations are also considered Surgery.

Therapy Service
The following services or supplies Prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Member:

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

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

- Dialysis
  The treatment that removes waste materials from the body for people with:
  - Acute renal failure; or
  - Chronic irreversible renal insufficiency.

- Infusion Therapy
  The infusion of:
  - Drug;
  - Hydration; or
  - Nutrition (parenteral or enteral);

  Into the body by a healthcare Provider.

  Infusion therapy includes: All professional services, supplies, and equipment that are required to safely and effectively administer the therapy.

  Infusion may be provided in a variety of settings (For example, home, office, Outpatient) depending on the level of skill required to:
  - Prepare the drug;
  - Administer the infusion; and
  - Monitor the Member.

  The type of healthcare Provider who can administer the infusion depends on whether the drug is considered to be a Specialty Drug infusion or a Standard Injectable Drug infusion, as determined by the Health Benefit Plan.

- Occupational Therapy
  Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal (nerve, muscle and bone) functions which have been impaired by:
  - Illness or injury;
  - Congenital anomaly (a birth defect); or
  - Prior therapeutic intervention.

  Occupational Therapy also includes medically prescribed treatment concerned with improving the Member's ability to perform those tasks required for independent functioning, where such function has been permanently lost or reduced by:
  - Illness or injury;
  - Congenital anomaly (birth defect); or
  - Prior therapeutic intervention (Prior treatment).

  This does NOT include services specifically directed towards the improvement of vocational skills and social functioning.

- Orthoptic/Pleoptic Therapy
  Medically Prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception.

  Such dysfunction results from:
  - Vision disorder;
  - Eye Surgery; or
  - Injury.

  Treatment involves a program which includes evaluation and training sessions.

- Physical Therapy
  Medically prescribed treatment of physical disabilities or impairments resulting from:
  - Disease;
  - Injury;
  - Congenital anomaly; or
  - Prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving:
    - Strength;
    - Mobility (or, Ambulation);
    - Endurance;
    - Balance;
    - Coordination;
    - Joint mobility;
    - Flexibility; and
    - The functional activities of daily living.

- Pulmonary Rehabilitation Therapy
  A multidisciplinary, comprehensive program for Members who have a chronic lung disease. Pulmonary rehabilitation is designed to:
  - Reduce symptoms of disease;
  - Improve functional status; and
  - Stabilize or reverse manifestations of the disease.

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

- Radiation Therapy
  The treatment of disease by any of the following, regardless of the method of delivery:
  - X-ray;
  - Gamma ray;
  - Accelerated particles;
  - Mesons;
  - Neutrons;
  - Radium or radioactive isotopes; or
  - Other radioactive substances.

- Speech Therapy
  Medically prescribed services that are necessary for the diagnosis and/or treatment of speech disorders, language disorders, and cognitive communication impairments that result in communication disabilities or dysphasia (swallowing disorder) due to:
  - Disease;
  - Surgery;
  - Injury;
  - Congenital and developmental anomalies; or
  - Previous therapeutic processes.

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

Urgent Care Center
Participating Facility Provider’s designed to offer immediate evaluation and treatment for sudden health conditions and accidental injuries that:
- Require medical attention in a non-emergency situation; and
- That cannot wait to be addressed by the Member's Primary Care Physician's office or Retail Clinic.

Urgent Care is not the same as: Emergency Services (see definition of Urgent Care above).

IMPORTANT NOTICES

Regarding Non-Discrimination Rights

The Member has the right to receive health care services without discrimination:

- based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity, pre-existing conditions, health status, and marital status;
- for medically necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Rights And Responsibilities

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

2025 PREVENTIVE SCHEDULE

This schedule is a reference tool for planning your preventive care. It lists items and services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended.

In accordance with the PPACA, this schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your healthcare provider is always your best resource for determining if you are at increased risk for a condition. Some services may require precertification/preapproval. If you have questions about this schedule, precertification/preapproval, or your benefit coverage, please call the Customer Service number on the back of your ID card.

PREVENTIVE CARE SERVICES FOR ADULTS

VISITS	
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: • High blood pressure screening • Behavioral counseling for skin cancer prevention • Obesity screening • Unhealthy drug use screening	One exam annually for all adults
SCREENINGS	
Abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males ages 65 to 75 years with a history of smoking
Anxiety Screening	Adults ages 64 years or younger
Barium Enema	Once every 5 years beginning at age 50. When limit is exhausted treat as diagnostic.
Colorectal cancer screening	Adults ages 45 to 75 years using any of the following tests: • Fecal occult blood testing: once a year • Highly sensitive fecal immunochemical testing: once a year • Flexible sigmoidoscopy: once every 5 years • CT colonography: once every 5 years • Stool DNA testing: once every 3 years • Colonoscopy: once every 10 years
Depression and suicide risk screening	All adults
Hepatitis B virus (HBV) screening	All asymptomatic adults at high risk for HBV infection

Hepatitis C virus (HCV) screening	All asymptomatic adults ages 18 years to 79 years
High blood pressure screening	Adults ages 18 years or older with increased risk once a year Adults ages 18 to 39 years with no other risk factors once every 3 to 5 years Adults ages 40 years or older once a year
Human immunodeficiency virus (HIV) screening	All adults
Latent tuberculosis infection screening	Asymptomatic adults ages 18 years or older at increased risk for tuberculosis
Lipid disorder screening	Adults 40 years or older once every 4 years
Lung cancer screening	Adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
Prediabetes and type 2 diabetes mellitus screening and intensive counseling interventions	Abnormal blood glucose and type 2 diabetes screening for adults ages 35 to 70 years who are overweight or obese Intensive behavioral counseling interventions for individuals ages 35 to 70 years who are overweight or obese with abnormal blood glucose up to 32 sessions per year
Prostate Screening	Prostate screening beginning at age 40. • One Digital Rectal Exam per benefit period • One prostate specific antigen screening per benefit period When limit is exhausted treat as diagnostic.
Syphilis infection screening	All adults at increased risk for syphilis infection
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence Behavioral counseling in a primary care setting for individuals with a positive screening result
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Behavioral interventions for weight loss to prevent obesity-related morbidity and mortality	Behavioral intervention for adults with a body mass index (BMI) of 30 kg/m^2 or higher
Exercise interventions for the prevention of falls	Community-dwelling adults age 65 years and older with an increased risk of falls
Behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults diagnosed as overweight or obese with known cardiovascular disease risk factors
Nutritional counseling for weight management	6 visits per year for all individuals Adults with behavioral health conditions that impact weight or nutritional status

Tobacco use counseling	All adults who use tobacco products
Work-up and follow-up services for pre-exposure prophylaxis for the prevention of HIV	Adults at high risk for HIV infection
MEDICATIONS	
Pre-exposure prophylaxis for the prevention of HIV infection	Adults at high risk for HIV infection
Prescription bowel preparation	Adults 45 years and older when used in conjunction with a preventive colorectal cancer screening procedure, i.e., flexible sigmoidoscopy, colonoscopy, virtual colonoscopy
Statins for the primary prevention of cardiovascular disease	Adults ages 40 to 75 with no history of cardiovascular disease, with one or more risk factor for cardiovascular disease and a 10-year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

IMMUNIZATIONS
Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	
Prenatal Care Visits Services that may be provided during the prenatal care visits include, but are not limited to the following: • Preeclampsia Screening	For all pregnant females
Postpartum Care Visit	For all postpartum females
Well-woman visits Services that may be provided during the well-woman visit include but are not limited to the following: • BRCA-related cancer risk assessment • Counseling for the prevention of obesity • Discussion of chemoprevention for breast cancer • Instruction on fertility awareness-based methods, including the lactation amenorrhea method • Intimate partner violence screening • Primary care interventions to promote and support breastfeeding • Recommended preventive preconception and prenatal care services • Urinary incontinence Screening	At least annually
SCREENINGS	
Anxiety Screening	All females
Bacteriuria screening	All asymptomatic pregnant females at 12 to 16 weeks' gestation or at the first prenatal visit, if later
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adolescents and adults
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	Genetic counseling for asymptomatic females with an ancestry associated with BRCA gene mutations, personal history or family history of a BRCA-related cancer BRCA mutation testing, as indicated, following genetic counseling
Breast cancer screening (2D or 3D mammography)	All females ages 40 years and older

Cervical cancer screening (Pap test)	Ages 21 to 65: Every 3 years Ages 30 to 65: Every 5 years with a combination of Pap test and human papillomavirus (HPV) testing, for those who want to lengthen the screening interval
Chlamydia and Gonorrhea screening	Sexually active females ages 24 years and younger or older sexually active females who are at increased risk for infection
Counseling interventions to prevent perinatal depression	Pregnant or postpartum females at increased risk for perinatal depression without a current diagnosis of depression 20 sessions over a 70-week period
Diabetes screening after pregnancy	Females with a history of gestational diabetes who are currently not pregnant and who have not been previously diagnosed with type 2 diabetes mellitus
Depression and suicide risk screening	All pregnant and postpartum females
Gestational diabetes mellitus screening	Asymptomatic pregnant females after 24 weeks of gestation or at the first prenatal visit for pregnant females identified to be at high risk for diabetes
Hepatitis B virus (HBV) screening	All pregnant females or asymptomatic adolescents and adults at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All pregnant females All individuals ages 15 years and older All children under age 15 years at increased risk of infection
Human papillomavirus (HPV) screening	Ages 30 years and older: Every 5 years Ages 30 to 65 years: Every 5 years with a combination of Pap test and HPV testing, for those that want to lengthen the screening interval
Osteoporosis (bone mineral density) screening	Every 2 years for females younger than age 65 years who are at increased risk for osteoporosis Every 2 years for females ages 65 years and older without a history of osteoporotic fracture or without a history of osteoporosis secondary to another condition
RhD incompatibility screening	All pregnant females and follow-up testing for females at higher risk
Syphilis screening	All pregnant females at first prenatal visit For high-risk pregnant females, repeat testing in the third trimester and at delivery Females at increased risk for syphilis infection
Tobacco use counseling	All pregnant females who smoke tobacco products

Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all pregnant females Behavioral counseling in a primary care setting with a positive screening result

MEDICATIONS	
Breast cancer chemoprevention	Asymptomatic females ages 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention
Folic acid	Daily folic acid supplements for all females planning for or capable of pregnancy
Low-dose aspirin	Aspirin for pregnant females who are at high risk for preeclampsia after 12 weeks of gestation
MISCELLANEOUS	
Breastfeeding supplies/support/counseling	Comprehensive lactation support/counseling for all pregnant women and during the postpartum period Breastfeeding supplies
Reproductive education and counseling, contraception, and sterilization	All females with reproductive capacity

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pediatric prenatal exams	All expectant parents for the purpose of establishing a pediatric medical home
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: • Behavioral counseling for skin cancer prevention • Blood pressure screening • Congenital heart defect screening • Counseling and education provided by healthcare providers to prevent initiation of tobacco use • Developmental surveillance • Dyslipidemia risk assessment • Hearing risk assessment for children 29 days or older • Height, weight, and body mass index measurements • Obesity screening • Oral health risk assessment • Risk assessment of sudden cardiac arrest and sudden cardiac death	All children up to age 21 years, with preventive exams provided at: • 3-5 days after birth • By 1 month • 2 months • 4 months • 6 months • 9 months • 12 months • 15 months • 18 months • 24 months • 30 months • 3 years-21 years: annual exams
SCREENINGS	
Alcohol, tobacco, and drug use screening and behavioral counseling intervention	Annually for all children ages 11 years and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
Anxiety screening	For children ages 8 years and older
Autism and developmental screening	All children
Behavioral/social/emotional screening	All children
Bilirubin screening	All newborns
Chlamydia screening	All sexually active children up to age 21 years
Depression and suicide risk screening	Annually for all children ages 12 years to 21 years
Dyslipidemia screening	Following a positive risk assessment or in children where laboratory testing is indicated
Gonorrhea screening	All sexually active children up to age 21 years
Hearing screening for newborns	All newborns
Hearing screening for children 29 days or older	Following a positive risk assessment or in children where hearing screening is indicated

Hepatitis B virus (HBV) screening	All asymptomatic adolescents at high risk for HBV infection
Human immunodeficiency virus (HIV) screening	All children
Iron deficiency screening	All children
Lead poisoning screening	All children at risk of lead exposure
Newborn screening panel (for example, congenital hypothyroidism, hemoglobinopathies {sickle cell disease}, phenylketonuria {PKU})	All newborns
Syphilis screening	All sexually active children up to age 21 years
Vision screening	All children up to age 21 years
ADDITIONAL SCREENING SERVICES AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	Semiannually for all sexually active adolescents
Nutritional Counseling for Weight Management	6 visits per year for all individuals Adults with behavioral health conditions that impact weight or nutritional status
Obesity screening and behavioral counseling	Screening is part of the preventive exam for children ages 6 years and older. Behavioral counseling for children ages 6 years and older with an age- and sex-specific body mass index (BMI) in the 95th percentile or greater
MEDICATIONS	
Fluoride	Oral fluoride for children ages 6 months to 16 years whose water supply is deficient in fluoride
Prophylactic ocular topical medication for gonorrhea	All newborns within 24 hours after birth
MISCELLANEOUS	
Fluoride varnish application	Every 3 months for all infants and children starting at age of primary tooth eruption to age 12 years
Tuberculosis testing	All children up to age 21 years

IMMUNIZATIONS (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)
Children Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

PREMIUM DRUG PROGRAM®

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

QCC INSURANCE COMPANY
(Hereafter called "The Claims Administrator")

Your benefits are entirely funded by your employer. QCC Insurance Company provides administrative and claims payment services only.

BASIC PRESCRIPTION DRUG PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discrimination Is Against the Law

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

This plan:

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

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

If you believe that this Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: our Civil Rights Coordinator, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: **civilrightscoordinator@1901market.com**.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

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BASIC PRESCRIPTION DRUG PROGRAM

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SECTION 1.

INTRODUCTION

This Benefit Booklet has been prepared so that the Member may become acquainted with the Prescription Drug program available to employees who are eligible and enrolled in it. The benefits described are subject to the terms of the Group Program Document issued by QCC Insurance Company (referred to as the Health Benefit Plan). Changes impacting this Benefit Booklet will be evidenced by a Notice of Change to the Benefit Booklet and/or a revised edition of the Benefit Booklet.

Benefits will not be available for services to a greater extent or for a longer period than is Medically Necessary, as determined by the Claims Administrator. The amount of benefits for Prescription Drugs will not be more than the amount charged by the Pharmacy and will not be greater than any maximum amount or limit described or referred to in this Benefit Booklet.

See "Important Notice" below:

Important Notice: Regarding Experimental Drugs Or Investigative Drugs

The Claims Administrator does not cover Drugs it determines to be experimental or investigative in nature because those Drugs are not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Claims Administrator acknowledges that situations exist when a Member and the Member's Physician agree to utilize Experimental Drugs or Investigative Drugs. If a Member is prescribed and dispensed Experimental Drugs or Investigative Drugs, the Member shall be responsible for the cost of the Drugs. A Member or the Member's Physician may contact the Claims Administrator to determine whether a Drug is considered an Experimental Drug or Investigative Drug. The term "Experimental Drug or Investigative Drug" is defined in the ***Important Definitions*** section of this Benefit Booklet.

Important Notice: Regarding Treatment Which Is Not Medically Necessary

The Claims Administrator only covers Drugs which it determines Medically Necessary. A Member Pharmacy accepts our decision and will not bill the Member for Drugs which the Claims Administrator determines are not Medically Necessary without the Member's consent. A Non-Member Pharmacy, however, is not obligated to accept the Claims Administrator's determination and the Member may not be reimbursed for Drugs which the Claims Administrator determines are not Medically Necessary. The Member is responsible for these charges when Drugs are dispensed by a Non-Member Pharmacy. The Member can avoid these charges simply by choosing a Member Pharmacy for their care.

The terms "Medically Necessary", "Member Pharmacy", and "Non-Member Pharmacy" are defined in the ***Important Definitions*** section of this Benefit Booklet.

Important Notice: Regarding Drugs Used For Cosmetic Purposes

The Claims Administrator does not cover Drugs which it determines are prescribed for cosmetic purposes because they are not necessitated as part of the Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Claims Administrator acknowledges that situations exist when a Member and the Member's Physician decide to pursue a course utilizing Drugs used for Cosmetic Purposes. In such cases, the Member is responsible for the cost of the Drugs. A Member or the Member's Physician may contact the Claims Administrator to determine whether a Drug is considered prescribed for cosmetic purposes.

The term "Drugs used for Cosmetic Purposes" is defined in the ***Important Definitions*** section of this Benefit Booklet.

Regarding Non-Discrimination Rights:

The Member has the right to receive health care services without discrimination:

- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity, pre-existing conditions, health status, and marital status;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Discretionary Authority

The Claims Administrator or Plan Administrator, as applicable, retains discretionary authority to interpret the benefit plan and the facts presented to make benefit determinations. Benefits under this Program will be provided only if the Claims Administrator or Plan Administrator, as applicable, determines in its discretion that the Member is entitled to them.

SECTION 2.

PRESCRIPTION DRUG BENEFITS

Subject to the Exclusions, conditions and limitations of the Program, a Member is entitled to benefits for Prescription Drugs as described in this Benefit Booklet's ***Prescription Drug Benefits*** section subject to any Copayment, Coinsurance or Deductible, and in the amounts as specified below. For services which are not provided by a Member Pharmacy, the Member may pay a higher Copayment, Coinsurance level and/or Deductible as described below.

Prescription Drugs Ordered From A Member Pharmacy
Benefits will be provided for covered Prescription Drugs appearing on the Drug Formulary and that are prescribed by a Physician and dispensed by a Member Pharmacy in accordance with the Prescription Drug Order presented by the Member or the Member's Health Care Practitioner. Benefits are available for up to a 30 day supply, or the appropriate therapeutic limit, whichever is less.

Benefits are also available for diabetic supplies such as blood testing strips, insulin syringes and lancets. A Member Pharmacy will furnish requested Prescription Drugs in accordance with the terms and conditions of the Group Program Document and will not collect from or charge a Member any amount in excess of the applicable Copayment and Coinsurance, and/or Deductible.

The Claims Administrator 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 "Copayments And Coinsurance" subsection of the ***Prescription Drug Benefits*** section for Member Pharmacies. 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'.

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

Prescription Drugs Ordered From A Non-Member Pharmacy
Benefits will be provided for covered Prescription Drugs appearing on the Drug Formulary and that are prescribed by a Physician and dispensed to a Member for Prescription Drugs purchased by a Member from a Non-Member Pharmacy if:

- Prescription Drugs were dispensed subject to a Prescription Drug Order;
- The Member submits to the Claims Administrator a completed claim form and proper proof of payment; and
- The Prescription Drug is not excluded under the Group Program Document.

The Claims Administrator shall reimburse the Member's Allowable Charges less any applicable Deductible, Copayment and Coinsurance for up to a 30 day supply of the purchased Prescription Drug, or the appropriate therapeutic limit, whichever is less.

Prescription Drugs Ordered From A Member Mail Order Pharmacy
Benefits shall be provided for covered Prescription Drugs appearing on the Drug Formulary, for chronic conditions ordered by mail by a Member or the Member's prescribing Health Care Practitioner and submits to a Member Mail Order Pharmacy a written Prescription Drug Order specifying the amount of the Prescription Drug to be supplied. Benefits shall be available for up to a 90 day supply of a Covered Drug, or the appropriate therapeutic limit, whichever is less, subject to the amount specified in the Prescription Drug Order and applicable law. In addition, benefits shall also be provided for covered Prescription Drugs prescribed by a Physician for a chronic condition and dispensed by a designated retail Pharmacy or a participating Act 207 retail Pharmacy. The cost sharing indicated in the "Copayments and Coinsurance" subsection for Member Mail Order Pharmacies will apply. Benefits are available for up to a 90-day supply. To verify that a retail Pharmacy is a designated retail Pharmacy or a participating Act 207 Pharmacy, access www.ibx.com.

Prescription Drugs Ordered From A Non-Member Mail Order Pharmacy
No benefits shall be provided for Prescription Drugs obtained by mail from a Non-Member Mail Order Pharmacy.

Refills Of Prescription Drug Orders
If the applicable Prescription Drug Order and law allow, benefits shall be provided for refills of Prescription Drugs obtained from a Member Pharmacy, a Non-Member Pharmacy, or a Member Mail Order Pharmacy according to the terms and conditions set out above. No benefits shall be provided for refills of Prescription Drugs obtained by mail from a Non-Member Mail Order Pharmacy.

Ordering And Delivery Costs
Except for benefits described herein for Prescription Drugs obtained from a Member Mail Order Pharmacy, benefits shall not be provided for costs associated with ordering and/or delivery of drugs from pharmacies. Such costs include, but are not limited to, transportation, telephone, mail, courier or parcel service costs.

Copayments And Coinsurance
Benefits for Prescription Drugs are subject to payment by a Member of the following amounts to the dispensing Pharmacy:

- Member Pharmacies:
  - $20 per Prescription Drug Order or refill for a Generic Prescription Drug.
  - $75 per Prescription Drug Order or refill for a Preferred Brand Prescription Drug and diabetic supplies, except for glucometers and lancets.
  - $100 per Prescription Drug Order or refill for a Non-Preferred Drug Prescription Drug.
- Non-Member Pharmacies:
  70% of Allowable Charges per Prescription Drug Order or refill for Covered Prescription Drugs and diabetic supplies.
- Member Mail Order Pharmacies†:
  - $20 per Prescription Drug Order or refill for up to a 30 day supply of a Generic Prescription Drug.
  - $40 per Prescription Drug Order or refill for a 31-90 day supply of a Generic Prescription Drug.
  - $75 per Prescription Drug Order or refill for up to a 30 day supply of a Preferred Brand Prescription Drug and diabetic supplies, except for glucometers and lancets.
  - $150 per Prescription Drug Order or refill for a 31-90 day supply of a Preferred Brand Prescription Drug and diabetic supplies, except for glucometers and lancets.
  - $100 per Prescription Drug Order or refill for up to a 30 day supply of a Non-Preferred Drug Prescription Drug.
  - $200 per Prescription Drug Order or refill for a 31-90 day supply of a Non-Preferred Drug Prescription Drug.

The cost-sharing amounts for a specialty Drug prescription or for certain other high-cost Prescription Drugs set forth above are applicable to those Prescription Drugs dispensed to a Member who does not receive cost-sharing assistance such as coupons provided by a drug manufacturer. In the event a Member does elect to receive such cost-sharing assistance, amounts paid or credited by a drug manufacturer on behalf of a Member will not accrue toward the satisfaction of the Member’s Deductible or Out-of-Pocket Limit. Additionally, each separate Prescription Order or refill for the Prescription Drug will be paid by the Claims Administrator subject to the Member's Coinsurance of 30%. Members who exhaust cost-sharing assistance available from a manufacturer will not be responsible for more cost-sharing for the Prescription Drug or refill than the amount for which they were responsible while receiving such cost-sharing assistance.

Out-of-pocket expenses incurred by a Member for Prescription Drug benefits will be included in the calculation of the Member's overall medical plan out-of-pocket limit.

For questions concerning whether a particular Prescription Drug appears on the Drug Formulary, the Member may call the Member Services telephone number referenced on the Member's Identification Card. Information about criteria and formulary exceptions can be found in the formulary guide located on the pharmacy benefits manager's website. The Member may also obtain information about how to request an exception by calling Customer Service at the phone number on the Identification Card.

Administrative Procedures
Members shall comply with administrative procedures established and furnished to Members by the Claims Administrator and Pharmacy Benefits Manager to obtain the benefits described in the Program. Such procedures shall include, but are not limited to, using forms supplied by a Member Mail Order Pharmacy to order Covered Drugs from Member Mail Order Pharmacy, and submitting to the Member Mail Order Pharmacy a brief history of Member's Prescription Drug usage.

Information about criteria and how cost-share will be determined for tier and formulary exceptions can be found in the Formulary Exception Policy. Tier exceptions can only be requested for coverage of Non-Preferred Drugs at the preferred drug tier for brand drugs or at the generic tier for generic products. The policy is available at www.ibx.com/formularyexceptionspolicy. The Member may request a hardcopy of the policy or obtain information about how to request an exception by calling Customer Service at the phone number on the Identification Card.

SECTION 3.

PRESCRIPTION DRUG EXCLUSIONS

Except as specifically provided in this Benefit Booklet, no benefits shall be provided for the following:

- Drugs not appearing on the Drug Formulary, except where an exception has been granted;

- Drugs dispensed without a Prescription Drug Order except insulin and diabetic supplies, such as diabetic blood testing strips, lancets and glucometers;

- Prescription Drugs for which there is an equivalent that does not require a Prescription Drug Order (That is, over-the-counter medicines), whether or not prescribed by a physician. This exclusion does not apply to insulin and certain drugs that are specifically designated by the Claims Administrator;

- Drugs obtained through mail order Prescription Drug services of a Non-Member Mail Order Pharmacy;

- Devices of any type, even though such devices may require a Prescription Drug Order including, but not limited to, ostomy supplies, therapeutic devices, artificial appliances, hypodermic needles, syringes, vials or similar devices. This exclusion does not apply to:
  - Devices used for the treatment or maintenance of diabetic conditions and syringes used for the injection of insulin; and
  - Devices known as spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines;

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

- Drugs dispensed to a Member while a patient in a facility including, but not limited to, a hospital, skilled nursing facility, institution, Health Care Practitioner's office or freestanding facility;

- Drugs which are not Medically Necessary as determined by the Claims Administrator;

- Drugs used for cosmetic purposes as determined by the Claims Administrator as not part of the Medically Necessary treatment of an illness, injury or congenital birth defect;

- Drugs which are experimental or investigative in nature as determined by the Claims Administrator;

- Drugs which are not prescribed by an appropriately licensed Health Care Practitioner;

- Drugs prescribed for persons other than the requesting Employee or their Dependents;

- Injectable drugs, including infusion therapy drugs that are covered under the Group's medical plan;

- Drugs for any loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation or losses sustained or expenses incurred; as a result of enemy action or act of war, whether declared or undeclared;

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

- Drugs for any occupational illness or bodily injury arising out of, or in the course of, employment for which the Member has a valid and collectible benefit under any Workers' Compensation Law, Occupational Disease Law, United States Longshoremen's Act or Harbor Worker's Compensation Act, whether or not the Member claims the benefits or compensation;

- Drugs for injuries resulting from the maintenance or use of a motor vehicle if such Drugs are paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan;

- Drugs for which the Member would have no obligation to pay;

- Drugs furnished without charge to the Member;

- Drugs which have been paid under the Claims Administrator 's Comprehensive Major Medical or Personal Choice Contract, covering this same Employer Group;

- Pharmacological therapy for weight reduction or diet agents;

- Dietary Supplements, amino acid supplements, health foods, and prescription vitamins except for pre-natal and pediatric vitamins;

- Smoking deterrent agents. This exclusion does not apply to prescribed smoking deterrent agents;

- Injectables used for the treatment of infertility when they are prescribed solely to enhance or facilitate conception;

- The administration or injection of Drugs;

- Blood and blood products;

- Intravenous drugs and intravenous solutions administered by home infusion companies;

- Drugs for a use not approved by the U.S. Food and Drug Administration;

- Drugs not approved by the Claims Administrator or prescribed drug amounts exceeding the eligible dosage limits established by the Claims Administrator.

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

  Monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease (For example, aducsnumab-avwa)

  Delandistrogene moxeparvovec

  Tofersen

  Exon skipping drugs for Duchenne Muscular Dystrophy (DMD) (For example, Eteplirsen, Golodirsen, Viltolarsen, Casimersen)

  Lecanemab-irmb (Leqembi)

SECTION 4.

ELIGIBILITY UNDER THE PROGRAM

Effective Date: The date the Group agrees that all Eligible Persons may apply and become covered for the benefits as set forth in the Program and described in this Benefit Booklet.

Eligible Person
The Member is eligible to be covered under this Prescription Drug Program if the Member is determined by the Group as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by the Member's physical condition and determination of eligibility for the coverage by the Employer shall be final and binding.

Eligible Dependent
The Member's family is eligible for coverage (Dependent coverage) when the Member is eligible for Employee coverage. An Eligible Dependent is defined as the Member's spouse under a legally valid existing marriage, the Member's children whom the Member continuously financially support or whose coverage is the Member's responsibility under the terms of a qualified medical child support order (including stepchildren, children legally placed for adoption and the Member or the Member's spouse's legally adopted children). The limiting age for covered children is the first of the month following the month in which they reach age 26.

In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from an Accredited Educational Institution. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.

A full-time student who is eligible for coverage under the coverage who is:
- A member of the Pennsylvania National Guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or
- A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch. 76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

As proof of eligibility, the Employee must submit a form to the Claims Administrator approved by the Department of Military & Veterans Affairs (DMVA):

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

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on the Member for over half of their support. The Claims Administrator may require proof of the Member's eligibility under the prior Claims Administrator 's plan and also from time to time under this Prescription Drug Program.

The newborn child(ren) of any Member shall be entitled to the benefits provided by the Claims Administrator from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, the Member must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, the Member must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under this coverage on the date the Dependent is acquired provided that the Member applies to the Claims Administrator for addition of the Dependent within 31 days after the Dependent is acquired and the Member makes timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after the Member's Application is accepted by the Claims Administrator.

A Dependent child of a custodial parent covered under this coverage may be enrolled under the terms of a qualified release or court order, as required by law.

A Domestic Partner, including the child of a Domestic Partner, shall be considered for eligibility under the coverage as if they were the child of the Applicant, as long as the Domestic Partnership exists.

No Dependent may be eligible for coverage as a Dependent of more than one Employee of the Enrolled Group. No individual may be eligible for coverage hereunder as an Employee and as a Dependent of an Employee at the same time.

SECTION 5.

GENERAL INFORMATION

Benefits To Which Members Are Entitled

The liability of the Claims Administrator is limited to the benefits specified in this Benefit Booklet and as set forth in the Group Program document. No person other than a Member is entitled to receive benefits as provided under this Program. Benefits for Covered Services specified under the Program will be provided only for services and supplies that are rendered by a provider specified in the ***Important Definitions*** section of this Benefit Booklet.

Termination Of Coverage At Termination Of Employment Or Membership In The Group

When a Member ceases to be an Eligible Employee or Eligible Dependent, or the required contribution is not paid, the Member's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Program are provided by and/or approved by the Claims Administrator before the Claims Administrator receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Claims Administrator will consider the effective date of termination of a Member under this Program to be not more than 60 days before the first day of the month in which the Contractholder notified the Claims Administrator of such termination.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or the Employee's eligible Dependents to temporarily extend health care coverage.

Continuation Of Incapacitated Child

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Member for over half of their support, the Member may apply to the Claims Administrator to continue coverage of such child under this Program upon such terms and conditions as the Claims Administrator may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 26.

The disability must be certified by the attending Physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over the limiting age and joining the Claims Administrator for the first time, the handicapped child must have been covered under the prior Claims Administrator and submit proof from the prior Claims Administrator that the child was covered as a handicapped person.

When The Member Files A Claim
When the Member needs to file a claim, the Member should fill out the claim form and return it with the Member's itemized bills to QCC Insurance Company no later than 20 days after the Member's Prescription Drugs are provided to the Member. The claim should include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the Prescription Drugs are rendered.

If it was not possible to file the claim within the 20-day period, the Member's benefits will not be reduced, but in no event will the Claims Administrator be required to accept the claim more than two years after the end of the Benefit Period in which the Prescription Drugs were rendered.

Release Of Information
Each Member agrees that any person or entity having information relating to an illness or injury, for which benefits are claimed under this Program, may furnish to the Claims Administrator any information (including copies of records relating to the illness or injury).

In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request.

The Claims Administrator shall provide to the Contractholder at the Contractholder's request certain information regarding claims and charges submitted to the Claims Administrator in a mutually acceptable format. The parties understand that any information provided to the Contractholder will be adjusted by the Claims Administrator to prevent the disclosure of the identity of any Member or other patient treated by said providers. The Contractholder shall reimburse the Claims Administrator for the actual costs of preparing and providing said information.

The Claims Administrator may also furnish membership and/or coverage information to affiliated Claims Administrator s or other entities for the purpose of claims processing or facilitating patient care.

Limitation Of Actions
No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than three years after the date Covered Drugs are dispensed.

Claim Forms
The Claims Administrator will furnish to the Member making the claim, or to the Contractholder, for delivery to such Member, such forms as are required for filing proof of loss.

Member/Provider Relationship

- The choice of a provider is solely the Member's.
- The Claims Administrator does not furnish Covered Drugs but only makes payment for Covered Drugs received by Members. The Claims Administrator is not liable for any act or omission of any provider. The Claims Administrator has no responsibility for a provider's failure or refusal to render Covered Drugs to a Member.

Agency Relationships

The Contractholder is the agent of the Member, not the Claims Administrator.

Identification Cards And Benefit Booklets

The Claims Administrator will provide Identification Cards to Members or to the Contractholder, depending on the direction of the Contractholder. The Claims Administrator will also provide to each Member of an Enrolled Group a Benefit Booklet describing the benefits provided under the Group Contract .

Applicable Law

The Group Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

Member Rights

A Member shall have no rights or privileges as to the benefits provided under this Program except as specifically provided herein.

Assignment

The Group Contract and the benefits hereunder are not assignable by the Contractholder or any Member in whole or in part to any person, Pharmacy or other entity, except where required by law in the case of a custodial parent of a Dependent covered under the Group Contract .

Notice

Any notice required under the Group Contract must be in writing. Notice given to a Member will be given to the Member in care of the Contractholder, or sent to the Member's last address furnished to the Claims Administrator by the Contractholder. The Contractholder, the , or a Member may, by written notice, indicate a new address for giving notice.

Subrogation and Reimbursement Rights

The Employee Retirement Income Security Act (ERISA) applies to many health benefit plans and, to comply with legal requirements that relate specifically to ERISA-governed plans, this Benefit Booklet describes "Subrogation and Reimbursement Rights" in two sections:

- Subrogation and Reimbursement Rights When The Program Is Governed By ERISA; and
- Subrogation and Reimbursement Rights When The Program Is Not Governed By ERISA.

However, the fact that these Rights are described in separate sections using different language does not mean or imply that the Rights are substantively different or that the Rights described in one section are greater or lesser than the Rights described in the other section. Under both sections, the Claims Administrator reserves right the pursue subrogation recoveries and the Member has an obligation to fully reimburse the Claims Administrator to the fullest extent permitted by law.

- **Subrogation and Reimbursement Rights When The Program Is Governed By ERISA**

  By accepting benefits for Covered Services, the Member agrees that the Claims Administrator has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

  The Claims Administrator or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

  Subrogation Rights
  Subrogation rights arise when the Claims Administrator pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Claims Administrator is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Claims Administrator "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Claims Administrator has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

  Reimbursement Rights
  If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Claims Administrator for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The Claims Administrator has a right to full reimbursement.

Lien
By accepting benefits for Covered Services from the Claims Administrator, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Claims Administrator the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Claims Administrator to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Claims Administrator has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Claims Administrator is reimbursed in full.

Constructive Trust
If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Claims Administrator has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of Claims Administrator to the full extent that the Claims Administrator has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Claims Administrator.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Claims Administrator is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Claims Administrator to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Claims Administrator will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Claims Administrator will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Claims Administrator agrees to do so in writing. The recovery rights of the Claims Administrator will not be reduced by the "common fund" doctrine.

- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Claims Administrator will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Claims Administrator is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Claims Administrator or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Claims Administrator or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Claims Administrator or its delegated representative.
- Fully cooperate with the Claims Administrator and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Claims Administrator's ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Claims Administrator or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Claims Administrator paid benefits for an injury or illness.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

- **Subrogation and Reimbursement Rights When The Program Is Not Governed By ERISA**

By accepting benefits for Allowable Charges, the Member agrees that the Claims Administrator has the right to enforce subrogation and reimbursement rights to the extent permitted by law. This section explains these rights and the responsibilities of

each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Claims Administrator or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented. The right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

Subrogation Rights
Subrogation rights arise when the Claims Administrator pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Claims Administrator is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Claims Administrator "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Claims Administrator has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Claims Administrator to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

Reimbursement Rights
If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Claims Administrator for all medical expenses that were paid to the Member or on the Member's behalf, to the extent permitted by law.

- These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
- These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
- These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.
- The Claims Administrator will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Claims Administrator agrees to do so in writing.

- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Claims Administrator will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits.
- All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Claims Administrator is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

Obligations of Member

- Immediately notify the Claims Administrator or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
- Immediately notify the Claims Administrator or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
- Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Claims Administrator or its delegated representative.
- Fully cooperate with the Claims Administrator and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
- Avoid taking any action that may prejudice or harm the Claims Administrator’s ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
- Fully reimburse the Claims Administrator or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
- All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

IMPORTANT: Failure to Cooperate

If the Member fails or refuses to sign forms or documents as requested or otherwise fail or refuse to cooperate or abide by any of the obligations described above, the Claims Administrator or Plan Administrator, as applicable, has full discretion and authority to reduce or withhold benefit payments to recover subrogation/reimbursement amounts that are owed and/or to terminate the Member's participation in the Program.

Professional Judgment
A Pharmacist shall not be required to fill any Prescription Drug Order which in their professional judgment should not be filled.

Delivery Of Prescription Drugs
The Claims Administrator shall not be responsible for delay in the delivery of a Prescription Drug.

Limitations Of Health Benefit Plan Liability
The Claims Administrator shall not be liable for injuries or damage resulting from acts or omissions of any Claims Administrator officer or Member or of any provider or other person furnishing services or supplies to the Member; nor shall the Claims Administrator be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

Liability For Prescription Drugs
- The Claims Administrator shall not be liable for any claims or demand arising out of, on in connection with, the manufacturing, compounding, dispensing or use of any drug covered under this Program.
- The Claims Administrator shall not be liable for any abuse, physical dependency, or overdose which is the result of the Member's misuse or mismanagement of a Prescription Drug.
- If the Claims Administrator determines Prescription Drug usage by the Member or the Member's Eligible Dependents appears to exceed usage generally considered appropriate under the circumstances, the Claims Administrator shall have the right to direct the Member or the Member's Eligible Dependents to one Pharmacy for all future Prescription Drug Covered Services.
- In certain cases, the Claims Administrator may determine that the use of certain Prescription Drugs for a Member's medical condition requires pre-certification for Medical Necessity. The Claims Administrator also reserves the right to establish eligible dosage limits of certain Prescription Drugs covered by the Claims Administrator.

Payment Of Providers
A Pharmacy Benefits Manager (PBM) administers our Prescription Drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The Claims Administrator anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under some circumstances, the Claims Administrator may use a portion of the rebates received from its PBM to lower the drug price used for purposes of determining what the Member should pay based on Member benefits at the time a rebatable drug is dispensed to the Member at an In-Network Pharmacy. Under most benefit plans, Prescription Drugs are subject to a Member's cost-sharing, including Copayment, Coinsurance and Deductible, as applicable.

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

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

Special Circumstances, as recognized in the community, and by the Claims Administrator and appropriate regulatory authority, are extraordinary circumstances not within the control of the Claims Administrator, including but not limited to:
- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot;
- Civil insurrection; or
- Public health emergency.

SECTION 6.

RESOLVING PROBLEMS

(COMPLAINT AND APPEAL PROCESS)

Informal Member Complaint Process
The Claims Administrator has a process for Members to express informal Complaints. To register a Complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their Identification Card or write to the Claims Administrator at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member Complaint, it will be investigated, and the Member will receive a response in writing within 30 days.

Member Appeal Process
Filing an Appeal
The Claims Administrator maintains procedures for the resolution of Member appeals. Internal appeals may be filed within 180 calendar days of the Member's or designee's receipt of an adverse benefit determination from the Claims Administrator. The Member may designate either the Provider or another authorized representative to represent the Member on the appeal. After obtaining the Member's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be the Member's representative for the appeal, the Member must complete a valid authorization form. The Member should contact the Claims Administrator as directed below to obtain a "Member/Enrollee Authorization to Appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Member Appeals Department	Toll Free Phone: 1-888-671-5276
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820	Phila. Fax: 215-988-6558

The Member or designee is entitled to a full and fair review. Specifically, at all appeal levels the Member or designee may submit additional information pertaining to the case, to the Claims Administrator. The Member or designee may specify the remedy or

corrective action being sought. At the Member's request, the Claims Administrator will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Claims Administrator will automatically provide the Member or designee with any new or additional evidence considered, relied upon, or generated by the Claims Administrator in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or designee at no charge.

The Claims Administrator will not terminate or reduce an-ongoing course of treatment without providing the Member or designee with advance notice and the opportunity for advanced review.

Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

If the appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Member may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Member or designee may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.

Types of Appeals
Following are the two types of appeals and the issues they address:

- **Internal Standard (non-urgent) Medical Necessity Appeals** - An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on medical judgement and the exclusions for Experimental/Investigative or cosmetic services. A Claim Administrator's Medical Director (MDR) is the decision maker for Medical Necessity appeals. This individual holds an active unrestricted license to practice medicine. Either the Claim Administrator's MDR or an independent consultant function as the same/similar specialist. The same/similar specialist is in the same/similar specialty as the individual who is managing the Member's care. The independent consultant is a licensed Physician, Psychologist, or other health care professional, who has no previous involvement with the case and is not a subordinate of anyone previously involved in the case.

  For each of the two levels of Medical Necessity appeal, a different MDR is the decider of the appeal. For both levels of appeal, the MDR has no previous involvement with the case and is not a subordinate of anyone previously involved.

The same/similar specialist review is typically part of the first level appeal. However, if additional information is submitted prior to the second level of appeal, an MDR or independent consultant who has no previous involvement with the case and is not the subordinate of anyone who was previously involved in the case, conducts a second same/similar specialist review.

- **Administrative Appeal** - A dispute or objection by a Member regarding the following: operations or management policies of a health care plan, non-covered services, coverage limitations, participating or non-participating provider status, cost sharing requirements, certain surprise medical bills received by a Member from an out-of-network Provider, and rescissions of coverage (except for failure to pay premiums or coverage contributions), that has not been resolved by the Claims Administrator. An employee of the Claims Administrator is the decision maker for the level 1 Administrative Appeal. This individual has had no previous involvement with the case and is not a subordinate of anyone involved with a previous adverse determination. A different employee of the Claims Administrator decides the level 2 appeal. This individual has no prior involvement in the case and is not the subordinate of anyone previously involved.

Internal Standard Appeals
Pre-service Appeal - An appeal for benefits that, under the terms of this Group Program Document, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained for coverage to be available. For a standard Pre-Service Appeal, a maximum of 15 calendar days is available for each of the two levels of internal appeal.

Post-service Appeal - An appeal for benefits that is not a Pre-service Appeal. (Post-service Appeals concerning claims for services that the Member has already obtained do not qualify for review as Expedited/Urgent appeals.) For a standard Post-Service Appeal, a maximum of 30 calendar days is available for each of the two levels of internal appeal.

For prescription non-formulary exception requests, the decision is made, and notification is sent to the Member/designee within 72 hours for each level of appeal.

The decision of the Claims Administrator is sent to the Member or designee in writing within the timeframe noted above.

Internal Urgent/Expedited Appeals Review:
An urgent expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

The appeals review process for an urgent/expedited appeal mirrors the process described above under the section entitled "Types of Appeal".

The expedited review is completed promptly based on the Member's health condition, but no later than 72 hours after receipt of the expedited appeal request by the Claims Administrator. Within 72 hours after receipt of the expedited appeal, the Claims Administrator notifies the Member or designee by telephone of the determination. The determination is sent in writing within 72 hours after the Member or designee has received the verbal notification.

For prescription non-formulary exception requests, the Claims Administrator notifies the Member or designee of the determination in writing within 24 hours after the receipt of the request from the Member or designee.

The Member or designee may also file an expedited external Medical Necessity appeal at the same time as filing an internal expedited Medical Necessity appeal.

If not satisfied with the standard or expedited decision from the Claims Administrator, the Member or designee has the right to initiate an external appeal as described below.

External Review Process via an Independent Review Organization (IRO)

Types of Services Eligible for An External Review
Under the Federal Independent Review Organization (IRO) process, Members or their designee may request an External Review that is based on any of the following:

- Medical Necessity and medical judgement appeals, including when a health care Provider requests an authorization for additional treatment that was not approved by the Plan.
- Appropriateness of service.
- Health care setting.
- Effectiveness of a covered benefit.
- Level of care.

When a Member seeks coverage for specialized care from an out-of-network health care Provider because they believe that an in-network health care Provider cannot effectively do the procedure or manage their care.

Disputes regarding the Program's compliance with the surprise billing and cost-sharing protections under Sections 2799a-1 and 2799a-2 of the Public Health Services Act and regulations promulgated thereunder, including:

- Any determination of whether an appeal is for emergency services or for consideration of compliance with the cost sharing and surprise billing protections.
- Clarification as to whether a claim for items and/or services from non-participating health care Providers at an in-network facility are subject to the No Surprise Act protections.

- Clarification as to whether an individual was in a condition to receive a notice about the No Surprise Act protections and have given informed consent to waive those protections.

Determine whether a claim for services and items is coded correctly and consistent with the treatment the individual received.

Determine whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network health care Provider at an in-network facility.

Rescissions of coverage, except for non-payment of premiums or coverage contributions

Standard External Review Process - The Claims Administrator follows the Federal Independent Review Organization (IRO) Process. The Member or designee may request an External Review via an IRO by calling or writing to the Claims Administrator within four months of receipt of the internal appeal decision letter. The Member or designee is not required to pay any of the costs associated with the External Review.

The Member or designee may only request an External Review after exhausting the Claims Administrator's internal appeal process. The Member or designee shall be deemed to have exhausted the internal appeal process if the Claims Administrator has failed to comply with the requirements of the internal claims, utilization review and or appeals process, unless the failure or failures are based on de minimis (minor) violations that do not cause and are not likely to cause prejudice or harm to the Member or designee.

Preliminary Review
Within five business days of the Claims Administrator's receipt of an External Appeal request from the Member or designee, the Claims Administrator conducts a preliminary review of the request to determine the following:

- The Member is or was covered at the time the health care service or item was requested (in the case where services or items require pre-authorization) or provided in the case of retrospective reviews.
- The adverse benefit determination or final adverse benefit determination does not relate to the Member's failure to meet the eligibility requirements under the terms of the Program.
- The Member has exhausted the Program's internal appeal process.
- The Member has provided all the information and forms required to process an external appeal.

Within one business day after completion of the preliminary review, the Claims Administrator sends written notification to the Member or designee. If the request is complete but not eligible for an external review, the notice must include the reasons for the lack of ineligibility.

If additional information or material is needed for the Claims Administrator to process the external appeal request, the notification identifies that information. The Member or designee has 48 hours from their receipt of the notification to submit the required information to the Claims Administrator.

If the request is eligible, the Claims Administrator assigns the external review to an IRO which is accredited by a nationally recognized accrediting organization such as NCQA (National Committee for Quality Assurance). The IRO referral process provides for the following:

- The Claims Administrator ensures that the IRO process is not biased.
- The Claims Administrator contracts with four separate IROs and rotates assignments among them.
- As required by Federal law, the IRO is not eligible for financial incentives based on the likelihood they will support the denial.
- The IRO has no direct or indirect professional, familial, or financial conflicts of interest with the Claims Administrator, with the Member, or the designee. The Claims Administrator's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest.
- The consultant assigned by the IRO to review the appeal request, has no prior involvement with the case and is not a subordinate of anyone previously involved.
- The assigned consultant is in the same/similar specialty as the individual managing the Member’s care.

Within five business days of the IRO assignment, the Claims Administrator sends the IRO all the information and documents considered in making the adverse determination electronically via the applicable IRO portal.

For a standard external review, the IRO makes the decision and sends notification to the Member or designee within 45 calendar days of their receipt of the request. For prescription non-formulary exception requests, the IRO sends notification to the Member or designee within 72 hours of their receipt of the request.

Expedited External Review Process

The Member or designee may request an External Review for urgent/expedited situations through an IRO. Additionally, the Member or the designee may request a concurrent internal and external expedited external review. The Member or designee is not required to pay any of the costs.

Preliminary Review - Immediately upon request for an external expedited appeal, the Claims Administrator determines the eligibility and reviewability of the request as follows.

- The Member is or was covered at the time the health care service or item was requested (in the case where services or items require pre-authorization) or provided in the case of retrospective reviews.

- The adverse benefit determination or final adverse benefit determination does not relate to the Member's failure to meet eligibility requirements under the terms of the Program.
- The Member has provided all the information and forms required to process an expedited external appeal.

Upon determination that an expedited external review request is eligible for an external review, the Claims Administrator assigns an IRO and electronically sends all information and documents considered in the adverse benefit determination to the IRO via the applicable portal.

The IRO reviews the case file, makes a decision, and sends notification to the Member or designee within 72 hours of their receipt of the external appeal request. For prescription non-formulary exception requests, the IRO reviews the case file, makes the decision, and notifies the Member or designee within 24 hours of their receipt of the request.

All IRO overturn decisions (both standard and expedited) are binding on the Claims Administrator and Plan Administrator. If the decision of the IRO is that the services are eligible, the Claims Administrator authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment and/or approval of the service in the event of an overturn of the Internal Appeal. The Claims Administrator implements the IRO's decision within the time, if any, specified by the IRO.

SECTION 7.

IMPORTANT DEFINITIONS

For the purpose of this Program, the terms below have the following meaning:

Accredited Educational Institution
A publicly or privately operated academic institution of higher learning which:
- Provides recognized courses or a course of instruction.
- Confers any of the following, when a student completes the course of study:
  - A diploma;
  - A degree; or
  - Another recognized certification of completion.
- Is duly recognized, and declared as such, by the appropriate authority, as follows:
  - An authority of the state in which such institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to Colleges and Universities; and Technical or specialized schools.

Allowable Charges
For services rendered by a Member Pharmacy, the amount that the Claims Administrator has negotiated to pay the Member Pharmacy as total reimbursement for Prescription Drugs, and for services rendered by a Non-Member Pharmacy, the lesser of the Non-Member Pharmacy's charges for the Covered Drug, or 150% of Average Wholesale Price for the same Covered Drug.

Applicant and Employee/Member
Applicant and Employee/Member shall mean you, the individual who applies for coverage which the Claims Administrator has entered into with the Employer/Group. For Purposes of this Program, Employee and Member are interchangeable terms.

Application and Application Card
The request, either written or via electronic transfer, of the Applicant for benefits under this Program, set forth in a format approved by the Claims Administrator, whether such written request was made under a prior Program that has been superseded by this Program, or under this Program.

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

Brand Name or Brand Name Drug
A Prescription Drug approved by the U.S. Food and Drug Administration (FDA) through the new drug application (NDA) process and in compliance with applicable state law and regulations. For purposes of this Program, the term "Brand Name Drug" shall also include Authorized Generics and devices which includes spacers for metered dose inhalers that are used to enhance the effectiveness of inhaled medicines.

Chronic Drugs
A Covered Drug recognized by the Claims Administrator for the treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis. For purposes of the Program, the term "Chronic Drugs" shall also mean the following diabetic supplies that may not require a Prescription Drug Order:

- Insulin syringes;
- Diabetic blood testing strips; and
- Lancets.

Coinsurance
A percentage of Allowable Charges which must be paid by the Member toward the cost for filling or refilling a Prescription Drug Order for Prescription Drugs.

Complaint
Any expression of dissatisfaction, verbal or written, by a Member.

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

Copayment
A specified amount which must be paid by the Member toward the cost for filling or refilling a Prescription Drug Order for Prescription Drugs.

Cosmetic Drug or Drugs Used For Cosmetic Purposes
Drugs which are determined by the Claims Administrator to be:

- For other than the treatment of illness, injuries, congenital birth defect or restoration of physiological function; or
- For cleansing, beautifying, promoting attractiveness or altering the appearance of any part of the human body.

Covered Drug
Prescription Drugs, including Self-Administered Prescription Drugs, which are:

- Appearing on the Drug Formulary, or where an exception has been granted;
- Prescribed for a Member by a Health Care Practitioner who is appropriately licensed to prescribe Drugs;

- Prescribed for a use that has been approved by the Federal Food and Drug Administration; and
- Medically Necessary, as determined by the Claims Administrator.

Insulin shall be considered a Covered Drug where Medically Necessary.

Deductible
A specified amount of Allowable Charges, usually expressed in dollars, that must be Incurred by a Member before the Claims Administrator will assume any liability for all or part of the remaining Allowable Charges.

Dentist
A person who is a Doctor of Dentistry Science (DDS) or a Doctor of Dental Medicine (D.M.D.), licensed and legally entitled to practice dentistry and dispense drugs.

Dependent
- The Applicant's spouse under a legally valid existing marriage.
- The children, (including stepchildren, children legally placed for adoption, and legally adopted children of the Applicant or the Applicant's spouse) who are continuously financially supported by the Applicant, or whose coverage is the responsibility of the Applicant under the terms of a qualified release or court order. The limiting age for covered children is the first of the month following the month in which they reach age 26.

Domestic Partner (Domestic Partnership)
A Domestic Partner, including the child of a Domestic Partner, shall be considered for eligibility under the Program as if they were the child of the Applicant, as long as the domestic partnership exists.

A member of a Domestic Partnership is one of two partners, each of whom:
- Is unmarried, at least 18 years of age, resides with the other partner and intends to continue to reside with the other partner for an indefinite period of time;
- Is not related to the other partner by adoption or blood;
- Is the sole Domestic Partner of the other partner, with whom the person has a close committed and personal relationship, and has been a member of this Domestic Partnership for the last six months;
- Agrees to be jointly responsible for the basic living expenses and welfare of the other partner;
- Meets (or agrees to meet) the requirements of any applicable federal, state, or local laws or ordinances for Domestic Partnerships; and
- Demonstrates financial interdependence by submission of proof of three or more of the following documents:
  - A Domestic Partner agreement;
  - A joint mortgage or lease;
  - A designation of one of the partners as beneficiary in the other partner's will;
  - A durable property and health care powers of attorney;
  - A joint title to an automobile, or joint bank account or credit account; or

- Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

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

Drug
A substance which is:
- Recognized in the *Approved Drug Products with Therapeutic Equivalent and Evaluations* (The FDA Orange Book);
- Intended for use in the treatment of disease or injury; and
- Not a device or a component, part or accessory of a device.

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

Effective Date
According to the ***Eligibility Under The Program*** section, the date on which the Member's coverage begins.

Employee/Member
An individual of the Group who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

Experimental Drug or Investigative Drug
A drug, biological product, or select device which meets any of the following criteria:
- Is the subject of: Ongoing clinical trials;
- Is the research, experimental, study or investigational arm of an ongoing clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the Member's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Member's particular condition; or
- Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Member's particular condition, is recommended.

Any drug, biological product, or select device is not considered experimental/investigative if it meets all of the criteria listed below:
- When required, the drug, biological product, or select device must have final approval from the appropriate governmental regulatory bodies (For example, FDA).

- Reliable Evidence demonstrates that the drug, biological product, or select device meets technical standards, is clinically valid, and has a definite positive effect on health outcomes.
- Reliable Evidence demonstrates that the drug, biological product, select device leads to measurable improvement in health outcomes (That is, the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the drug, biological product, or select device is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the previous bullet, is possible in standard conditions of medical practice, outside clinical investigatory settings.
- Reliable Evidence shows that the prevailing opinion among experts regarding the drug, biological product, or select device is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

Any approval granted as an interim step in the FDA regulatory process (For example, An Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of a drug or biological product (For example, infusible agent) for another diagnosis, condition, or in a manner that does not align with the FDA approval shall require that one or more of the established reference Compendia identified in the Claims Administrator policies recognize the usage as appropriate medical treatment.

Family Coverage
Coverage for the Employee and one or more of the Employee's Dependents.

Generic Drug
Any form of a particular Prescription Drug which is:
- Sold by a manufacturer other than the original patent holder;
- Approved by the U.S. Food and Drug Administration as being generically equivalent through the FDA abbreviated new drug application (ANDA) process; and
- In compliance with applicable state laws and regulations.

Group or (Enrolled Group)
A group of Employees which has been accepted by the Claims Administrator, consisting of all those Applicants whose charges are remitted together with all the Employees and Dependents, listed on the Application Cards or amendments thereof, who have been accepted by the Claims Administrator.

Health Care Practitioner
A Physician, Dentist, podiatrist, nurse practitioner or other person licensed, registered and certified as required by law to prescribe Drugs in the course of their professional practice.

Identification Card
The currently effective card issued to the Member by the Claims Administrator.

Immediate Family
The Employee's:
- Spouse;
- Parent;
- Child, stepchild;
- Brother, sister; or
- Persons who ordinarily reside in the household of the Member.

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

Medically Necessary (Medical Necessity)
Shall mean:
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of:
  - Preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient, that are:
  - In accordance with generally accepted standards of medical practice;
  - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
  - Not primarily for the convenience of the patient, Physician, or other health care provider; and
  - Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- For these purposes, "generally accepted standards of medical practice" means standards that are based on:
  - Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, Physician Specialty Society recommendations; and
  - The views of Physicians practicing in relevant clinical areas; and
  - Any other relevant factors.

Member Mail Order Pharmacy
A Pharmacy which has entered into an agreement to provide the Claims Administrator's Members with the mail order prescription drug services described in the Program.

Member Pharmacy
A Pharmacy which has entered into an agreement to provide the Claims Administrator's Members with the prescription drug services described in the Program other than mail order prescription drug services.

Non-Member Mail Order Pharmacy
Any Pharmacy which has not entered into an agreement to provide the Claims Administrator's Members with mail order prescription drug services.

Non-Member Pharmacy
A Pharmacy which has not entered into an agreement to provide any prescription drug services to the Claims Administrator's Members.

Non-Preferred Drug
These drugs generally have one or more generic alternatives or preferred brand options within the same drug class. Some Generic Drugs are included in this category and are subject to the Non-Preferred Drug cost-sharing.

Pharmacist
A person who is legally licensed to practice the profession of Pharmacology and who regularly practices such profession in a Pharmacy.

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

Pharmacy Benefits Manager (PBM)
An entity that has entered into a contract with the Claims Administrator to perform prescription drug claims processing and related administrative services, and has agreed to arrange for the provision of pharmacy services to the Claims Administrator's Members.

Physician
A person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform surgery and dispense Drugs.

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

Prescription Drug
- Any medication which by federal and/or state laws may be dispensed with a Prescription Drug Order; and
- Insulin.

The list of covered Prescription Drugs is subject to change from time to time at the sole discretion of the Claims Administrator.

Prescription Drug Order
The request in accordance with applicable laws and regulations for medication issued by a Health Care Practitioner who is licensed to prescribe Drugs.

Reliable Evidence
Peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

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

Self-Injectable Prescription Drug (Self-Injectable Drug)
A Prescription Drug that:
- Is introduced into a muscle or under the skin by means of a syringe and needle; and
- Can be administered safely and effectively by either the Member or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required.

Independence

INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION[1]

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross[2] ("Independence") values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

Note: "Protected health information" or "PHI" is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

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

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

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[1] If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group's privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

[2] For purposes of this Notice, "Independence Blue Cross" refers to the following companies: Independence Blue Cross, Independence Assurance Company, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc. – independent licensees of the Blue Cross and Blue Shield Association

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

This revised Notice took effect on January 1, 2024, and will remain in effect until we replace or modify it.

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclose information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we

may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other Independence Blue Cross affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available Independence Blue Cross health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose “summary health information” to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. “Summary health information” is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor’s group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

Research: We may use or disclose your PHI for research purposes if certain conditions are

met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct certain Health Oversight Activities described below.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to

funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers' compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a "designated record set." Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called "Your Privacy Rights Concerning Your Protected Health Information."

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed Independence Blue Cross Personal Representative Designation Form and documentation that supports the person's qualification according to state law (such as a power of attorney or guardianship). To request the Independence Blue Cross Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be

notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Health Information Exchanges

We share your health information electronically through certain Health Information Exchanges ("HIEs"). A HIE is a secure electronic data sharing network. In accordance with applicable federal and state privacy and security requirements, regional health care providers participate in HIEs to exchange patient information in real-time to help facilitate delivery of health care, avoid duplication of services, and more efficiently coordinate care. As a participant in HIEs, Independence shares your health information we may have received when a claim has been submitted for services you have received among authorized participating providers, such as physicians, hospitals, and health systems for the purpose of treatment, payment and health care operations as permitted by law.
During an emergency, patients and their families may forget critical portions of their medical history which may be very important to the treating physician who is trying to make a quick, accurate diagnosis in order to treat the sick patient. Independence, through its participation in an HIE, makes pertinent medical history, including diagnoses, studies, lab results, medications and the treating physicians we may receive on a claim available to participating emergency room physicians while the patient is receiving care. This is invaluable to the physician, expediting the diagnosis and proper treatment of the patient.

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

As an Independence member, you have the right to opt-out which means your health information will not be accessible through the HIE. Through the regional HIE (https://healthshareexchange.org/patient-options-opt-out-back/) website or the State HIE (https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/Health-Information-Exchange-Citizens.aspx) website consumers or providers can access an online, fax, or mail form permitting patients to remove themselves (opt-out) or reinstate themselves (opt back in) to the HIE. It will take approximately one business day to process an opt-out request. If you choose to opt-out of the HIE, your health care providers will not be able to access your information through the HIE. Even if you opt-out, this will not prevent your health information from being made available and released through other means (i.e. fax, secure email) to authorized individuals, such as network providers for paying claims,

coordinating care, or administering your health benefits in accordance with the law and in the normal course of conducting our business as permitted under applicable law. For more information on HIEs, please go to https://healthshareexchange.org/consumers/ or to https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Information%20Technology/Health-Information-Exchange-Citizens.aspx.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved Independence Blue Cross Authorization Form. To request the Independence Blue Cross Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)
You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved Independence Blue Cross form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations, we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross's vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

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

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- before April 14, 2003.

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing

reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

Right to Notification of a Breach of Your PHI: You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Your Right to File a Privacy Complaint
If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross's privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your member ID card, or you may contact the Privacy Office as follows:

Independence Blue Cross Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 – 1762

Fax: 215-241-4023 or 1-888-678-7006 (toll-free)
E-mail: Privacy@ibx.com
Phone: 215-241-4735 or 1-888-678-7005 (toll-free)

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

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