Benefits Book

How your health plan works

PPO

Independence

Personal Choice

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Welcome to Independence Blue Cross

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

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

You will find valuable information about:

- What services are and are not covered by your health insurance
- How decisions are made about what is covered
- How to use our member website, **ibx.com**
- How to get in touch with us if you have a problem

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

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

Questions?

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

Introduction to your health plan

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

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

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

Using your member ID card

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

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

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

Stay informed

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

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

Get connected

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

Locating an in-network doctor or hospital

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

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

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

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

Rights and responsibilities

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

Using your benefits to receive care

Scheduling an appointment

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

Access after normal business hours

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

Services that require precertification

Precertification is an approval that your doctor must receive from us before you get coverage for certain services, genetic tests, and specialty drugs. A complete list of what requires precertification is available at ibx.com/precert.

Preventive care

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

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

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

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

Receiving care for behavioral health or substance use disorder

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

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

*Individual benefits must be verified.

Where to go for care

Emergency care

In the event of an emergency, go immediately to the emergency room of the nearest hospital. If you believe your situation is particularly severe, call 911 for assistance.

A medical emergency is typically thought of as a medical or psychiatric condition in which symptoms are so severe that the absence of immediate medical attention could place one's health in serious jeopardy. Most times, a hospital emergency room is not the most appropriate place for you to be treated.

Hospital emergency rooms provide emergency care and must prioritize patients' needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you could wait a long time.

Urgent care

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

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

Retail clinic

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

Virtual care

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

Not sure what care option to use?

Go to **ibx.com/findcarenow** to help you decide where to go for care.

You're covered while traveling with BlueCard® PPO

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

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

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

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

You can also visit an urgent care center for medical issues if an in-network provider is unavailable and if you do not require the medical services of the ER.

Out of town and need care?

Call **1-800-810-BLUE (TTY: 711)** or visit **bcbs.com** to find an in-network provider in your area.

Manage your benefits online

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

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

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

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

Finding care

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

- Use our simple provider search tool to find in-network doctors, hospitals, labs, and other providers
- Create a custom directory of your doctors
- Estimate what you will pay for an office visit or procedure based on your benefits

On-the-go access with the IBX app

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

Use the IBX app to:

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

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

One stop for the information you need

Log in at **ibx.com**.

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

Healthy savings

With Healthy Lifestyles℠ reimbursements, you can get money back for your healthy choices on fitness center and virtual subscription fees, weight management programs, and programs to help you quit tobacco. Learn more at ibx.globalfitrewards.com.

We also offer member-exclusive savings and discounts through several programs — Blue Insider℠, Blue365®, and HUSK Marketplace. Take advantage of savings on local, regional, and national businesses and attractions. Learn more at ibx.com/discounts.

Achieve Well-being

Our personalized digital tools and resources help you reach your health goals in a way that's simple, easy, and fun. Here's how it works:

- ✓ Complete your Well-being Profile and create an action plan
- ✓ Get reminders specific to your health goals
- ✓ Earn tokens and badges to celebrate your achievements
- ✓ Sync up fitness apps and devices to track your progress, create challenges, and invite friends

You may be eligible to receive Reward dollars by completing health-related activities. Please check your health plan to see if you are eligible for Rewards.

Log in at ibx.com to start your journey!

Connect with us

Get connected

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

Find us on social media

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

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

Member support

When you need us, we're here for you. You can contact us to discuss anything pertaining to your health care, including:

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

Language services are available

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

Call

Call the number on the back of your member ID card to speak to one of our experienced Customer Service team members, who are available to answer your questions Monday through Friday, 8 a.m. to 6 p.m.

Mail

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

Visit

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

Using your prescription drug benefits

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

Take a look at the advantages:

- **Easy to use.** A national network of retail pharmacies will recognize and accept your member identification (ID) card.
- **Low out-of-pocket expenses.** When you use an in-network pharmacy, your out-of-pocket costs are based on a discounted price, fixed copayments, or coinsurance.
- **No paperwork.** You don't have to file a claim form or wait for reimbursement when you use an in-network pharmacy.
- **High level of safety.** When you fill a prescription at an in-network pharmacy, your pharmacist can identify harmful drug interactions and other dangers by viewing your drug history.
- **Mail order and 90-day retail pharmacy options.** Mail order/home delivery may be available for medications you take regularly. You may also get a 90-day supply of maintenance medications at Rite Aid retail pharmacies for the same cost-share as mail order/home delivery to help make medication adherence easier and more affordable. Check your prescription drug benefits for specific details pertaining to the 90-day retail pharmacy benefit that may apply to your plan.

How to fill your prescription at a retail pharmacy

Present your ID card and your prescription at an in-network pharmacy for your plan. The pharmacist will confirm your eligibility for benefits and determine your share of the cost of your prescription. Your doctor may also electronically submit your prescription to your pharmacy.

In-network pharmacies

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

When you're traveling, you will find that most of the pharmacies in all 50 states accept your ID card and can fill your prescription for the same cost you pay at an in-network pharmacy at home.

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

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

Out-of-network pharmacies

If your prescription is filled at a pharmacy that does not participate in the network for your plan, you will have to pay the pharmacy's regular charge right at the counter. Then, depending on your plan design, you may submit a prescription reimbursement claim form for partial reimbursement to the address noted on the form. Your reimbursement check should arrive within 14 days from the day your claim form is received.

Keep in mind that your plan sponsor selected Independence Blue Cross (IBX) and/or its subsidiaries based in part on the discounted drug prices that the pharmacy benefits manager has negotiated. When you use an out-of-network pharmacy that has not agreed to charge a discounted price, it costs your plan more money; part of that cost is passed on to you.

Find a pharmacy

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

Understanding your prescription

We provide our members with comprehensive prescription drug coverage. The drug formulary includes generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. The formulary is reviewed regularly to ensure its continued effectiveness.

A brand drug is manufactured by only one company, which advertises and sells its product under a special trade name. In many cases, brand drugs are quite expensive, which is why your share of the cost is higher. Generic drugs are typically manufactured by several companies and are almost always less expensive than the brand drug. Generic drugs are approved by the U.S. Food and Drug Administration (FDA) to ensure they are as safe and effective as their brand counterparts. However, not every brand drug has a generic version.

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

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

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

If you're not sure if brand or generic drugs are right for you, talk to your doctor. The pharmacist may, on occasion, discuss with your doctor whether an alternative drug might be appropriate for you. Let your doctor know if you have a question about a change in prescription or if you prefer the original prescription. Your doctor makes the final decision on the necessity of you getting a brand drug.

Certain controlled substances and other prescribed medications may be subject to dispensing limitations. If you have any questions regarding your medication, please call the Pharmacy Benefits number on the back of your member ID card.

Brand vs. generic

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

Preventive drugs for adults and children

Your prescription drug plan includes 100 percent coverage for some preventive medications when received from an in-network pharmacy. This means that you won't have to pay copays, coinsurance, or deductibles for certain preventive medications with a prescription from your doctor. Receiving preventive care helps you stay healthy and may improve your overall health.

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

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

Mail order/home delivery

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

Mail order/home delivery is convenient and safe to use

If you choose mail order/home delivery, your doctor can prescribe a supply that will last up to 90 days. This means that you can get three times as many doses of your maintenance medication at one time through mail order/home delivery.

Mail order/home delivery prescriptions have been safely handled through the mail for many years. When your order is received, a team of registered, licensed pharmacists checks your prescription against the record of all drugs dispensed to you by an in-network pharmacy. This process ensures that every prescription is reviewed for safety and accuracy before it is mailed to you.

If there are questions about your prescription, a pharmacist will contact your doctor before your medication is dispensed. Your medication will be sent to your home within 14 days from the date your legible and complete order is received.

There may be times when you need a prescription right away. On these occasions, you should have your prescription filled at a local in-network pharmacy. If you need medication immediately, but you will be taking it on an ongoing basis, ask your doctor to write two separate prescriptions: you can have the first prescription filled locally for an initial 30-day supply of your medication, and you can use the second prescription to submit your mail order/home delivery request.*

How to request mail order/home delivery:

1. When you are prescribed a chronic or maintenance drug therapy, ask your doctor to write the prescription for a 90-day supply, plus refills. Make sure your doctor knows that you have a mail order/home delivery service so that you get one 90-day prescription and not three 30-day prescriptions (the cost of the three 30-day prescriptions may be more than the cost for one 90-day prescription). If you're taking medication now, ask your doctor for a new prescription.
2. Complete the Mail Service Order Form with your first order only. Forms and envelopes are available by calling the Pharmacy Benefits number on the back of your member ID card, or you can download the form when you log in at ibx.com.
3. Be sure to answer all the questions, and include your member ID number. An incomplete form can cause a delay in processing. Send the completed Mail Service Order Form, your original 90-day prescription, and your payment to OptumRx.
4. Your mail order/home delivery request will be processed and your medication sent to you within 14 days from the day it is received, along with instructions for future refills. Standard shipping is via U.S. Mail and is free of charge. Narcotic substances and refrigerated medicines will be shipped by FedEx® at no additional charge. Your order will be shipped to the address you provide on the form.
5. Mail order/home delivery requests can also be initiated when you log in at ibx.com.

Online services

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

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

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

How can my doctor order a prescription for me?

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

You will be dispensed the lower-priced generic drug (if manufactured) unless your doctor writes "brand medically necessary" or "dispense as written" on your prescription, or you indicate that you do not want the generic version of your brand drug on the Mail Service Order Form. A Mail Service Order Form will be included with each mail order/home delivery.

Paying for mail order/home delivery services

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

Mail order/home delivery refills

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

When you receive a medication through the mail order/home delivery service, you will also receive a notice showing the number of refills allowed by your doctor. To avoid the risk of being without your medication, mail the refill notice and your payment two weeks before you expect your present supply to run out. You can also manage and order your refills over the phone using the Pharmacy Benefits number on the back of your ID card.

The refill notice will include the date when you should reorder and the number of refills you have left. Remember, most prescriptions are valid for a maximum of one year. Please note: PRN (take as needed) refills in the Commonwealth of Pennsylvania are limited to five times or six months, whichever is less.

If you have any questions concerning this program, call the Pharmacy Benefits number on the back of your ID card.

Self-administered specialty drug coverage

Self-injectables and other oral specialty drugs that can be administered by you, the patient, or by a caregiver outside of the doctor's office are generally covered under your prescription drug benefits. Filling your prescription for a specialty drug via the OptumRx specialty pharmacy program can save you money and provide you with support by a pharmacist very experienced with specialty medications and their side effects.

The administration of a self-injectable drug by a medical professional is covered under your IBX medical benefit, even if you obtained the self-injectable through the OptumRx specialty pharmacy program. However, the drug itself will be covered under your prescription drug benefit.

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

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

Use your vision benefits

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

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

Freedom of provider choice

You have access to the national Davis Vision network, which includes more than 160,000 access points for independent eye care professionals and large retail and online providers like Visionworks, Befitting.com, Glasses.com, and 1800Contacts.com.

Low-cost frames and lens options

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

- Select frames from the Davis Vision Exclusive Collection, which are covered in full or with a minimal copay. An interactive frame try-on tool will allow you to see what the frames look like on before purchasing them.
- Choose from any in-network independent or retail provider's own frame collection and receive an allowance. This includes the following online providers: 1800Contacts.com, Befitting.com, and Glasses.com. You may have an enhanced frame allowance towards the purchase of frames at Visionworks stores. Please refer to your benefits for more information.

With fixed pricing on all lens styles and coatings, including blue light coatings, it's easy to predict your out-of-pocket costs. All frames and lenses provided by Davis Vision providers are warranted against breakage for one year from the original date of dispensing.

View your benefits online

Log in at ibx.com to:

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

Coverage for contacts and laser vision correction

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

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

Additional value-added services

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

Vision plan administered by DavisVision™

Independence

IBX

23214 3298612 (10-24)

THE PERSONAL CHOICE HEALTH BENEFITS PROGRAM

A COMPREHENSIVE MAJOR MEDICAL GROUP BENEFIT BOOKLET

By and Between

Independence Assurance Company
(Called "the Health Benefit Plan")
A Pennsylvania Corporation
Located at
1901 Market Street
Philadelphia, PA 19103

And

Group (Contractholder)
(Called "the Group")

The Health Benefit Plan certifies that the enrolled Employee and the enrolled Employee's eligible Dependents, if any are entitled to the benefits described in this Benefit Booklet, subject to the eligibility and Effective Date requirements.

This Benefit Booklet replaces any and all Benefit Booklets previously issued to the Member under any group contracts issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

The Contract is between the Health Benefit Plan and the Contractholder. This Benefit Booklet is a summary of the provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

INDEPENDENCE ASSURANCE COMPANY

Koleen Cavanaugh
SVP and Chief Marketing Officer

ATTEST:

Jonathan Stump
VP Product Services

Comprehensive Major Medical Coverage that utilizes a "Preferred" (In-Network) Provider Network to maximize benefits while offering Members the choice of selecting Out-of-Network Providers, except where specifically prohibited by the contract, subject to a reduction of benefits. This coverage utilizes extensive Precertification and utilization management procedures, which must be followed to maximize benefits and avoid penalties. Failure to obtain Precertification for services provided by a BlueCard Provider (excluding Inpatient Admissions) or an Out-of-Network Provider will result in a 20% reduction in benefits.

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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 1-800-572-3852 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yorùbá: ÀKÍYÈSÍ: Tí o bá nsọ Yorùbá, àwọn iṣẹ́ àtilẹ̀hìn èdè lọ́fẹ̀ẹ́ wà lárọ̀wọ́tó rẹ. Awọn iṣẹ́ àtilẹ̀hìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna iráàyèsi kíka wà lárọ̀wọ́tó 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

Thank you for joining Independence Assurance Company (the Health Benefit Plan). Our goal is to provide Members with access to quality health care coverage. This Benefit Booklet is a summary of the Members benefits and the procedures required in order to receive the benefits and services to which Members are entitled. Members' specific benefits covered by the Health Benefit Plan 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*** sections of this Benefit Booklet.

Please remember that this Benefit Booklet is a summary of the provisions and benefits provided in the Program selected by the Member's Group. Additional information is contained in the Group Contract available through the Member's Group benefits administrator. The information in this Benefit Booklet is subject to the provisions of the Group Contract. If changes are made to the Members Group's Program, the Member will be notified by the Members Group benefits administrator. Group Contract changes will apply to benefits for services received after the effective date of change.

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 Members Effective Date of coverage; or
- The Group Contract anniversary date coinciding with or next following that service's effective date.

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

Any rights of a Member to receive benefits under the Group Contract 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 Group Contract 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	Contract Year (twelve (12) month period beginning on Group's Anniversary Date)	
	IN-NETWORK	**OUT-OF-NETWORK**
Program Deductible[(I)]		
Individual	$2,000	$5,000
Family	$4,000	$15,000

Note for Program Deductible shown above: In each Benefit Period, the Deductibles shown above apply to all Covered Services except as otherwise specified in the ***Schedule of Covered Services***. In each Benefit Period, the Family Deductible will be applied to all family members covered under a Family Coverage. A Deductible will not be applied to any covered family member once the Family Deductible has been satisfied for all covered family members combined. The In-Network Care Individual Deductible and In-Network Care Family Deductible amounts may be subject to an annual cost of living adjustment for high deductible health plans that are compatible with a health savings account. Any annual adjustment will be made in accordance with Internal Revenue Code section 223. Members will be notified in advance of any changes to the In-Network Care Individual Deductible and In-Network Care Family Deductible amounts.

Coinsurance[(I)]	20% for Covered Services, except as otherwise specified in the ***Schedule of Covered Services***.	50% for Covered Services, except as otherwise specified in the ***Schedule of Covered Services***.
Out-of-Pocket Limit		
Individual	$4,000	$10,000
Family	$8,000	$20,000

Note for Out-of-Pocket Limit shown above: When a Member Incurs the level of In-Network Out-of-Pocket expenses listed above of Copayments, Deductible and Coinsurance expense in one Benefit Period for In-Network Covered Services, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of the Benefit Period. After the Family In-Network Out-of-Pocket Limit amount have been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of the Benefit Period. However, no family member will contribute more than the individual In-Network Out-of-Pocket amount. The amount of the In-Network Care Individual Out-of-Pocket Limit and In-Network Care Family Out-of-Pocket Limit will only include expenses for Essential Health Benefits. The In-Network dollar amount specified above shall not include any expense Incurred for Penalties associated with failure to Precertify required services or for amounts that exceed the Health Benefit Plan's payment (see the ***Covered Expense*** definition for details). When a Member Incurs the level of Out-of-Network Out-of-Pocket expenses listed above of Coinsurance expense in one Benefit Period for Out-of-Network Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of the Benefit Period. After the Family Out-of-Network Out-of-Pocket Limit amount have been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance will be reduced to 0% for the balance of the Benefit Period. The Out-of-Network dollar amount specified above shall not include any expense Incurred for any Deductible, Copayments or Penalties associated with failure to Precertify required services or for amounts that exceed the Health Benefit Plan's payment (see the ***Covered Expense*** definition for details). The

amount of the In-Network Care Individual Out-of-Pocket Limit and In-Network Care Family Out-of-Pocket Limit may be subject to an annual cost of living adjustment for high deductible health plans that are compatible with a health savings account. Any annual adjustment will be made in accordance with Internal Revenue Code section 223. Members will be notified in advance of any changes to the In-Network Care Individual Out-of-Pocket Limit and In-Network Care Family Out-of-Pocket Limit amounts.		
Lifetime Maximum	Unlimited	Unlimited

SCHEDULE OF COVERED SERVICES

This ***Schedule of Covered Services*** is an overview of the benefits you are entitled to. More details can be found in the ***Description of Covered Services*** section.

Subject to the exclusions, conditions and limitations of this Program, a Member is entitled to benefits for the Covered Services described in this ***Schedule of Covered Services*** during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. The percentages for Coinsurance and Covered Services shown in this ***Schedule of Covered Services*** are not always calculated on actual charges. For an explanation on how Coinsurance is calculated, see the "Covered Expense" definition in the ***Important Definitions*** section.

Some Covered Services must be Precertified before the Member receives the services. Failure to obtain a required Precertification for a Covered Service could result in a reduction of benefits. More information on Precertification is found in the ***General Information*** section.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Acupuncture[4]	20%, after Deductible	50%, after Deductible
Note for Acupuncture shown above: Benefit Period Maximum: 18 In-Network/Out-of-Network visits		
Alcohol Or Drug Abuse And Dependency[3]		
Inpatient Hospital Detoxification and Rehabilitation	20%, after Deductible*	50%, after Deductible**
Hospital and Non-Hospital Residential Care	20%, after Deductible*	50%, after Deductible**
Outpatient Treatment		
Office Visit	20%, after Deductible	50%, after Deductible
All Other	20%, after Deductible	50%, after Deductible
Telebehavioral Health	None, after Deductible	50%, after Deductible
* In-Network Benefit Period Maximum: Unlimited Inpatient days. This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. ** Out-of-Network Benefit Period Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. This maximum is part of, not separate from, In-Network days maximum.		
Ambulance Services/Transport[4]		
Emergency	20%, after Deductible	20%, after In-Network Deductible
Non-Emergency	20%, after Deductible	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorders(4)	Same cost-sharing as any other medical service within the applicable medical service (For example, Therapy Services, Diagnostic Services, etc.)	Same cost-sharing as any other medical service within the applicable medical service (For example, Therapy Services, Diagnostic Services, etc.)
Note for Autism Spectrum Disorders shown above: Benefit Period Maximums and visit limits do not apply		
Blood(3)	20%, after Deductible	50%, after Deductible
Colorectal Cancer Screening(4)	20%, after Deductible	50%, after Deductible
Diabetic Education Program(4)	None, after Deductible	Not Covered
Diabetic Equipment And Supplies(4)	20%, after Deductible	50%, after Deductible
Durable Medical Equipment And Consumable Medical Supplies(4)	20%, after Deductible	50%, after Deductible
Emergency Care Services(4)	20%, after Deductible (not waived if admitted)	20%, after In-Network Deductible (not waived if admitted)
Home Health Care(4)	20%, after Deductible	50%, after Deductible
Note for Home Health Care shown above: Benefit Period Maximum: 60 visits. Benefit Period Maximum and cost-sharing do not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency		
Hospice Services(3)	20%, after Deductible	50%, after Deductible
Note for Hospice Services shown above: Respite Care: Maximum of seven In-Network/Out-of-Network days every six months		
Hospital Services(2)		
Facility Charge	20%, after Deductible*	50%, after Deductible**
Professional Charge	20%, after Deductible	50%, after Deductible
* In-Network Benefit Period Maximum: Unlimited Inpatient days.This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. ** Out-of-Network Benefit Period Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. This maximum is part of, not separate from, In-Network days maximum.		
Immunizations(1)	None, Deductible does not apply	50%, Deductible does not apply
Injectable Medications(4)		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Specialty Drug		
Home/Office	20%, after Deductible	50%, after Deductible
Outpatient	30%, after Deductible	50%, after Deductible
Standard Injectable Drugs	None, after Deductible	50%, after Deductible
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 Program Deductible or Out-of-Pocket Limit. Additionally, the Health Benefit Plan may elect to implement a program whereby each separate injected or infused drug will be paid by the Health Benefit Plan 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 Health Benefit Plan'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.		
Laboratory and Pathology Tests[4]		
Freestanding Laboratory	20%, after Deductible	50%, after Deductible
Hospital-Based Laboratory	30%, after Deductible	50%, after Deductible
Maternity/OB-GYN/Family Services[3]		
Assisted Reproductive Technology	20%, after Deductible	50%, after Deductible
Note for Assisted Reproductive Technology shown above: Lifetime Maximum: $15,000 of In-Network/Out-of-Network Covered Services across all fertility treatments		
Elective Abortions		
Professional Service	20%, after Deductible	50%, after Deductible
Outpatient Facility Charges	20%, after Deductible	50%, after Deductible
Maternity/Obstetrical Care		
Professional Service	20%, after Deductible	50%, after Deductible
Facility Service: Inpatient/Birthing Center	20%, after Deductible	50%, after Deductible
Newborn Care	20%, after Deductible	50%, after Deductible
Note for Newborn Care shown above: Cost-sharing does not apply for the first 31 days following birth		
Medical Care[2]	20%, after Deductible	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Medical Foods And Nutritional Formulas(4)	20% , after Deductible	50%, after Deductible
Mental Health/Psychiatric Care(3)		
Inpatient	20%, after Deductible*	50%, after Deductible**
Outpatient		
Office Visit	20%, after Deductible	50%, after Deductible
All Other	20%, after Deductible	50%, after Deductible
Telebehavioral Health	None, after Deductible	50%, after Deductible
* In-Network Benefit Period Maximum: Unlimited Inpatient days. This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. ** Out-of-Network Benefit Period Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency benefits. This maximum is part of, not separate from, In-Network days maximum.		
Methadone Treatment(4)	None, after Deductible	50%, after Deductible
Nutrition Counseling(1)	None, Deductible does not apply	50%, after Deductible
Note for Nutrition Counseling shown above: Benefit Period Maximum: 6 In-Network/Out-of-Network visits. Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency		
Observation Room(4)	20%, after Deductible	50%, after Deductible
Orthotics(4)	20%, after Deductible	50%, after Deductible
Podiatric Care(4)	20%, after Deductible	50%, after Deductible
Preventive Care - Adult(1)	None, Deductible does not apply	50%, Deductible does not apply
Routine/Preventive Colonoscopy		
Preventive Plus (P+) Facility/Non-Hospital based Facility*	None, Deductible does not apply	No Covered
Non-Preventive Plus (P+) Facility/Hospital based Facility	None, Deductible does not apply	50%, Deductible does not apply
* For $0 (None) Member cost-sharing to apply, all services must be performed by an In-Network gastroenterologist or a colon and rectal surgeon.		
Preventive Care - Pediatric(1)	None, Deductible does not apply	50%, Deductible does not apply

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Office Visits/Retail Clinics/Telemedicine Visits[1]		
Office Visits/Retail Clinics	20%, after Deductible	50%, after Deductible
Telemedicine Visits (excluding Retail Clinics)	20%, after Deductible	50%, after Deductible
Note for Primary Care Physician Office Visits/Retail Clinics/Telemedicine Visits shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply		
Prosthetic Devices[4]	20%, after Deductible	50%, after Deductible
Radiology Services - Non-Routine[4] (including MRI/MRA, CT scans, PET scans)		
Providers that are not Hospital based	20%, after Deductible	50%, after Deductible
Providers that are Hospital based	30%, after Deductible	50%, after Deductible
Radiology Services - Routine[4]		
Providers that are not Hospital based	20%, after Deductible	50%, after Deductible
Providers that are Hospital based	30%, after Deductible	50%, after Deductible
Skilled Nursing Facility Services[2]	20%, after Deductible	50%, after Deductible
Note for Skilled Nursing Facility Services shown above: Benefit Period Maximum: 120 In-Network/Out-of-Network Inpatient days Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency		
Sleep Studies[4]		
Home/Freestanding Sleep Center	20%, after Deductible	50%, after Deductible
Facility Charge	20%, after Deductible	50%, after Deductible
Smoking Cessation[1]	None, Deductible does not apply	50%, Deductible does not apply
Specialist Office/Telemedicine Visits[4]		
Office Visits	20%. after Deductible	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Telemedicine Visits	20%, after Deductible	50%, after Deductible
Note for Specialist Office/Telemedicine Visits shown above: If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply		
Spinal Manipulation Services(4)	20%, after Deductible	50%, after Deductible
Note for Spinal Manipulation Services shown above: Benefit Period Maximum: 20 In-Network/Out-of-Network visits		
Surgical Services(3)		
Outpatient Ambulatory Surgical Center	20%, after Deductible	50%, after Deductible
Outpatient Facility Charge	20%, after Deductible	50%, after Deductible
Outpatient Professional Charge	20%, after Deductible	50%, after Deductible
Outpatient Anesthesia	20%, after Deductible	50%, after Deductible
Second Surgical Opinion		
Office Visits	20%, after Deductible	50%, after Deductible
Telemedicine Visits	20%, after Deductible	50%, after Deductible
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 Health Benefit Plan will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure		
Therapy Services(4)		
Cardiac Rehabilitation Therapy	20%, after Deductible	50%, after Deductible
Note for Cardiac Rehabilitation Therapy shown above: Benefit Period Maximum: 36 In-Network/Out-of-Network sessions		
Chemotherapy	20%, after Deductible	50%, after Deductible
Dialysis	20%, after Deductible	50%, after Deductible
Infusion Therapy		
Home/Office	20%, after Deductible	50%, after Deductible
Outpatient	20%, after Deductible	50%, after Deductible
Physical Therapy/Occupational Therapy		
Providers that are not Hospital based	20%, after Deductible	50%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Providers that are Hospital based	20%, after Deductible	50%, after Deductible
Note for Physical Therapy/Occupational Therapy shown above: Benefit Period Maximum: 30 In-Network/Out-of-Network sessions of Physical Therapy/Occupational Therapy combined Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency		
Pulmonary Rehabilitation Therapy	20%, after Deductible	50%, after Deductible
Note for Pulmonary Rehabilitation Therapy shown above: Benefit Period Maximum: 36 In-Network/Out-of-Network sessions		
Radiation Therapy	20%, after Deductible	50%, after Deductible
Respiratory Therapy	20%, after Deductible	50%, after Deductible
Speech Therapy	20%, after Deductible	50%, after Deductible
Note for Speech Therapy shown above: Benefit Period Maximum: 20 In-Network/Out-of-Network sessions Benefit Period Maximum does not apply to services that are prescribed for Mental Health/Psychiatric Care and Treatment for Alcohol Or Drug Abuse And Dependency		
Transplant Services(3)		
Inpatient Facility Charges	20%, after Deductible	50%, after Deductible
Outpatient Facility Charges	20%, after Deductible	50%, after Deductible
Urgent Care Centers(4)	20%, after Deductible	50%, after Deductible
Virtual Care Services(4)		
Telemedicine Visit (Vendor/Virtual Provider)	20%, after Deductible	Not Covered
Teledermatology	20%, after Deductible	Not Covered
Telebehavioral Health	None, after Deductible	Not Covered
Women's Preventive Care(1)	None, Deductible does not apply	50%, Deductible does not apply

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs[(4)]		
Generic (Retail Pharmacy)	$10 Copayment Copayments apply after the In-Network Deductible is satisfied.	50%, after Deductible
Preferred Brand (Retail Pharmacy)	$35 Copayment Copayments apply after the In-Network Deductible is satisfied.	50%, after Deductible
Non-Preferred Drug (Retail Pharmacy)	$60 Copayment Copayments apply after the In-Network Deductible is satisfied.	50%, after Deductible
Generic (Mail Order)†	$10 Copayment per 30 day supply or $20 Copayment per 31-90 day supply Copayments apply after the In-Network Deductible is satisfied.	Not Covered
Preferred Brand (Mail Order)†	$35 Copayment per 30 day supply or $70 Copayment per 31-90 day supply Copayments apply after the In-Network Deductible is satisfied.	Not Covered
Non-Preferred Drug (Mail Order)†	$60 Copayment per 30 day supply or $120 Copayment per 31-90 day supply Copayments apply after the In-Network Deductible is satisfied.	Not Covered

† 31-90 day supplies of drugs to treat chronic conditions are available at the mail order Pharmacy and a designated retail Pharmacy

Note for Prescription Drugs shown above: Note for Prescription Drugs shown above: The dollar amount paid by a third party will not accumulate toward any applicable Deductible or Out-of-Pocket Limit to the extent permitted by law.

Contraceptives, mandated by the Women's Preventive Services provision of PPACA, are covered at 100% when obtained from an In-Network Pharmacy or In-Network Mail Order Pharmacy for certain generic products and brand products. All other contraceptive products are covered at standard cost-sharing as reflected in this *Schedule of Covered Services*

(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 during a Benefit Period, subject to any Copayment, Deductible, Coinsurance, Out-of-Pocket Limit or Lifetime Maximum. These amounts and percentages, and other cost-sharing requirements are specified in the ***Schedule of Covered Services***.

Covered Services may be provided by either an In-Network or Out-of-Network Provider. However, the Member will maximize the benefits available when Covered Services are provided by a Provider that belongs to the Personal Choice Network (an In-Network Provider) and has a contract with the Health Benefit Plan to provide services and supplies to the Member. The Member will be held harmless for Out-of-Network differentials if: an In-Network Provider fails to provide written notice to the Member of the Provider's Out-of-Network status for certain services; or, an In-Network Provider provides a written order for certain services to be performed by an In-Network Provider that has Out-of-Network status for those services and that Provider performs such service. The ***General Information*** section provides more detail regarding In-Network and Out-of-Network Providers, the Personal Choice Network, and the reimbursement of Covered Services provided by Facility Providers and Professional Providers.

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

PRIMARY AND PREVENTIVE CARE

A Member is entitled to benefits for Primary Care and Preventive Care Covered Services when deemed Medically Necessary and billed for by a Provider. Cost-sharing requirements 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 Health Benefit Plan 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 Health Benefit Plan reserves the right to modify the Preventive Schedule document at any

time. However, the Member has to be given a written notice of the change, before the change takes effect.

Immunizations
The Health Benefit Plan will provide coverage for the following:
- Pediatric immunizations;
- Adult immunizations; and
- The agents used for the immunizations.

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

Pediatric and adult immunization schedules can be found in the Preventive Schedule document.

The benefits for these pediatric immunizations are limited to Members under 21 years of age.

Nutrition Counseling
The Health Benefit Plan 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 Specialist; or
- By a Registered Dietitian (RD).

This benefit is in addition to any other nutrition counseling Covered Services described in this Benefit Booklet.

Osteoporosis Screening (Bone Mineral Density Testing or BMDT)
The Health Benefit Plan 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.

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

Preventive Care - Adult
The Health Benefit Plan will provide coverage for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

Preventive Care - Pediatric
The Health Benefit Plan will provide coverage for routine physical examinations, including a complete medical history, and other Covered Services, in accordance with the Preventive Schedule document.

Primary Care Physician Office Visits/Retail Clinics/Telemedicine Visits
The Health Benefit Plan will provide coverage for Medical Care visits, by a Primary Care Provider, for any of the following services:
- The examination of an illness or injury;

- The diagnosis of an illness or injury; and
- The treatment of an illness or injury.

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

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

Examples of treatment and services that are provided at a Retail Clinic include, but are not limited to:
- Sore throat;
- Ear, eye, or sinus infection;
- Allergies;
- Minor burns;
- Skin infections or rashes; and
- Pregnancy testing.

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

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
The Health Benefit Plan will provide 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 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*.
- Mammograms: Coverage will be provided for screening mammograms. The Health Benefit Plan will only provide coverage for benefits for mammography if the following applies:
  - It is performed by a qualified mammography service provider.
  - That service provider 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 Durable Medical Equipment supplier with Medical Necessity review; and coverage for lactation support and counseling provided during postpartum hospitalization, Mother's

Option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Member when provided by an In-Network 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 FDA approved contraceptive methods and patient education and counseling, are covered, only certain contraceptive drug options in each category are covered at no cost share to the Member when provided by an In-Network Provider. 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 by a Facility Provider and billed by a Provider; and
- Preapproved by the Health Benefit Plan.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

Hospital Services

- Ancillary Services

  The Health Benefit Plan 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.
- 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 Health Benefit Plan 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 Health Benefit Plan 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.

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

  A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, an admission occurring within ten calendar days of discharge date from a previous admission shall be treated as part of the previous admission.

  In computing the number of days of benefits:
  - The Health Benefit Plan will count the day of the Member's admission; but not the day of the Member's discharge.
  - If the Member is admitted and discharged on the same day, it will be counted as one day.

  The Health Benefit Plan will only provide coverage for days spent during an uninterrupted stay in a Hospital.

  It will not provide coverage for:
  - Time spent outside of the Hospital, if the Member interrupts the stay and then stay past midnight on the day the interruption occurs; or

- Time spent in the Hospital after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

Medical Care
The Health Benefit Plan 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 Professional Provider who is in charge of the case;
- While the Member is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility; and
- For a condition not related to Surgery, pregnancy, radiation therapy or Mental Illness.

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

- Concurrent Care
  The Health Benefit Plan will provide coverage for the following services, while the Member is an Inpatient, when they occur together:
  - Services rendered to the Member by a Professional Provider:
    - 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 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 Facility Provider's rules and regulations.

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

  Benefits are limited to one consultation per consultant during any Inpatient confinement.

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

Skilled Nursing Facility Services
The Health Benefit Plan will provide coverage for a Skilled Nursing Facility:

- When Medically Necessary as determined by the Health Benefit Plan.
- Up to the Maximum days specified in the ***Schedule of Covered Services***.

The Member must require treatment:
- By skilled nursing personnel;
- Which can be provided only on an Inpatient basis in a Skilled Nursing Facility.

A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, an admission occurring within ten calendar days of discharge date from any previous admission shall be treated as part of the previous admission.

In computing the number of days of benefits:
- The Health Benefit Plan will count the day of the Member's admission; but not the day of the Member's discharge.
- If the Member is admitted and discharged on the same day, it will be counted as one day.

The Health Benefit Plan will only provide coverage for days spent during an uninterrupted stay in a Skilled Nursing Facility.

It will not provide coverage for:
- Time spent outside of the Skilled Nursing Facility, if the Member interrupts their stay and then stays past midnight on the day the interruption occurs;
- Time spent if the Member remains past midnight of the day on which the interruption occurred; or
- Time spent in the Skilled Nursing Facility after the discharge hour that the Member's attending Physician has recommended that further Inpatient care is not required.

INPATIENT/OUTPATIENT SERVICES

The Member is entitled to benefits for Covered Services while the Member is an Inpatient in a Facility Provider or on an Outpatient basis when both of the following happen:
- Deemed Medically Necessary; and
- Billed for by a Provider.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

Blood
The Health Benefit Plan 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 drugs in the official formularies; and
  - Which have not been replaced by a donor.

Hospice Services
The Health Benefit Plan will provide coverage for palliative and supportive services provided to a terminally ill Member through a Hospice program by a Hospice Provider. This also includes

Respite Care.

- Who is eligible: The Member will be eligible for Hospice benefits if both of the following occur:
  - The Member's attending Physician certifies that the Member has a terminal illness, with a medical prognosis of six months or less; and
  - 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 Health Benefit Plan 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

- Assisted Reproductive Technology

  The Health Benefit Plan will provide coverage for Assisted Reproductive Technology Covered Services as defined in the ***Important Definitions*** section. Assisted Reproductive Technology Covered Services shall include, but are not limited to the following services and procedures:
  - Artificial insemination. Services performed by a Professional Provider for the promotion of fertilization of a recipient's own ova (eggs):
    - By the introduction of mature sperm from partner or donor into the recipient's vagina or uterus, with accompanying:
      - Simple sperm preparation;
      - Sperm washing; and/or
      - Thawing.
  - In vitro fertilization (IVF);
  - Zygote intrafallopian transfer (ZIFT);
  - Gamete intrafallopian transfer (GIFT);
  - Collection and preparation of ovum and semen;

Services performed for Assisted Reproductive Technology Covered Services must be performed by a Provider that conforms to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

- Elective Abortions
  The Health Benefit Plan will provide coverage for services provided in a Facility Provider that is a Hospital or Birth Center. It also includes services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member, which is a Covered Expense under this Program.

- Maternity/Obstetrical Care
  The Health Benefit Plan will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.
  - Pre-notification – The Health Benefit Plan should be notified of the need for maternity care within one month of the first prenatal visit to the Physician or midwife.
  - Facility and Professional Services – The Health Benefit Plan will provide coverage for:
    - Facility services: Provided by a Facility Provider that is a Hospital or Birth Center; and
    - Professional services: Performed by a Professional Provider or certified midwife.
  - Scope of Care – The Health Benefit Plan will provide coverage for:
    - Prenatal care; and
    - Postnatal care.
  - 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/Psychiatric Care
The Health Benefit Plan will provide coverage for the treatment of Mental Illness and Serious Mental Illness based on the services provided and reported by the Provider. Upon request, the Health Benefit Plan will make available the criteria for Medical Necessity determinations made under the Program for Mental Health/Psychiatric Care to any current or potential Member, Dependent or In-Network Provider.

- Regarding the provision of care other than Mental Health/Psychiatric Care: When a Provider renders Medical Care, other than Mental Health/Psychiatric Care, for a Member

with Mental Illness and Serious Mental Illness, payment for such Medical Care:
- Will be based on the Medical Benefits available; and
- Will not be subject to the Mental Health/Psychiatric Care limitations. Emergency Care will be considered In-Network Care.

- Inpatient Treatment
  The Health Benefit Plan will provide coverage, subject to the Benefit Period limitation(s) stated in the ***Schedule of Covered Services***, during an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be received from an In-Network Facility Provider and Inpatient visits for the treatment of Mental Illness and Serious Mental Illness must be performed by an In-Network Professional Provider.

  Covered Services include treatments such as:
  - Psychiatric visits;
  - Psychiatric consultations;
  - Individual and group psychotherapy;
  - Electroconvulsive therapy;
  - Psychological testing; and
  - Psychopharmacologic management.

  A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, an admission occurring within ten calendar days of discharge date from a previous admission shall be treated as part of the previous admission.

- Outpatient Treatment
  The Health Benefit Plan will provide coverage for Outpatient treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be performed by an In-Network Professional Provider/In-Network Facility Provider.

  Covered Services include treatments such as:
  - Psychiatric visits;
  - Psychiatric consultations;
  - Individual and group psychotherapy;
  - Licensed Clinical Social Worker visits;
  - Master's Prepared Therapist visits;
  - Telebehavioral Health services;
  - Electroconvulsive therapy;
  - Psychological testing;
  - Psychopharmacologic management; and
  - Psychoanalysis.

- Benefit Period Maximums for Mental Health/Psychiatric Care
  All Inpatient Mental Health/Psychiatric Care for both Mental Illness and Serious Mental Illness are covered up to the Maximum day amount(s) per Benefit Period specified in the ***Schedule of Covered Services***. Out-of-Network Benefit Period maximums are part of, not separate from, In-Network Benefit Period maximums.

Routine Patient Costs Associated With Qualifying Clinical Trials
- The Health Benefit Plan 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 Health Benefit Plan 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 an In-Network Professional Provider, and conducted in an In-Network Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by an In-Network Professional Provider, and in an In-Network Facility Provider, then the Health Benefit Plan will consider the services by an Out-of-Network Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see ***Important Definitions*** section) by the Health Benefit Plan.

Surgical Services
The Health Benefit Plan will provide coverage for surgical services provided:
- By a Professional Provider, and/or a 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 Health Benefit Plan 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;
  - 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; and
  - Routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

- <u>Anesthesia</u>
  - The Health Benefit Plan will provide coverage for the administration of Anesthesia:
    - In connection with the performance of Covered Services;
    - When rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider (except an

Obstetrician providing Anesthesia during labor and delivery and an oral surgeon providing services otherwise covered under this Benefit Booklet).

- 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 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 Health Benefit Plan 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 Health Benefit Plan.

  Surgical assistance is not covered when performed by a Professional Provider who themselves performs and bills for another surgical procedure during the same operative session.

- Hospital Admission for Dental Procedures or Dental Surgery

  The Health Benefit Plan 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 Health Benefit Plan will provide coverage for Covered Services provided by a Professional Provider and/or Facility Provider for:
  - 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 Health Benefit Plan reserves the right to seek recovery from the Provider.

The Health Benefit Plan has the right to decide which facts are needed. The Health Benefit Plan 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 Health Benefit Plan deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Health Benefit Plan such information as may be necessary to implement this provision.

- Second Surgical Opinion (Voluntary)
  The Health Benefit Plan 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 Professional Provider other than the one who initially recommended performing the Surgery.

Transplant Services

When a Member is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants, which are beyond the Experimental/Investigative stage. Benefits, are also provided for those services to the Member which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of Blood provided to a Member:

- 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 this Program. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or coverage by the Health Benefit Plan 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 this Program.
- When only the donor is a Member, the donor is entitled to the benefits of this Program for all related donor expenses, subject to the following additional limitations:
  - The benefits are limited to only those benefits not provided or available to the donor from any other source for funding or coverage in accordance with the terms of this Program; and
  - No benefits will be provided to the donor 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.

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 Health Benefit Plan will provide coverage for the care and treatment of Alcohol Or Drug Abuse And Dependency:
  - Provided by a licensed Hospital or licensed Facility Provider or an appropriately licensed behavioral health Provider.
  - Subject to the Maximum(s) shown in the ***Schedule of Covered Services***; and
  - According to the provisions outlined below.
- For maximum benefits, treatment must be received from an In-Network Provider.
- To Access Treatment for Alcohol Or Drug Abuse And Dependency:
  - Call the behavioral health management company at the phone number shown on the Members ID Card.

Upon request, the Health Benefit Plan will make available the criteria for Medical Necessity determinations made under the Program for Alcohol Or Drug Abuse And Dependency to any current or potential Member, Dependent or In-Network Provider.

- <u>Inpatient Treatment</u>
  - Inpatient Detoxification
    Covered Services include:
    - Lodging and dietary services;
    - Physician, Psychologist, nurse, certified addictions counselor, Master's Prepared Therapists, and trained staff services;
    - Diagnostic x-rays;
    - Psychiatric, psychological and medical laboratory testing; and
    - Drugs, medicines, use of equipment and supplies.

    A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, any admission occurring within ten calendar days of discharge date from any previous admission shall be treated as part of the previous admission.

  - Hospital and Non-Hospital Residential Treatment
    Hospital or Non-Hospital Residential Treatment of Alcohol Or Drug Abuse And Dependency shall be covered on the same basis as any other illness covered under this Program.

    Covered services include:
    - Lodging and dietary services;
    - Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
    - Rehabilitation therapy and counseling;
    - Family counseling and intervention;
    - Psychiatric, psychological and medical laboratory testing; and
    - Drugs, medicines, use of equipment and supplies.

    A Copayment may apply to an In-Network Inpatient Admission, if specified in the ***Schedule of Covered Services***. For purposes of calculating the total Copayment due, any admission occurring within ten calendar days of discharge date from any previous admission shall be treated as part of the previous admission.

- <u>Outpatient Treatment</u>

- Covered services include:
  - Diagnosis and treatment of substance abuse, including Outpatient Detoxification by the appropriately licensed behavioral health Provider;
  - Appropriately licensed behavioral health providers including Physician, Psychologist, nurse, certified addictions counselor, Master's Prepared Therapists, and trained staff services;
  - Telebehavioral Health services;
  - Rehabilitation therapy and counseling;
  - Family counseling and intervention;
  - Psychiatric, psychological and medical laboratory testing; and
  - Medication management and use of equipment and supplies.

OUTPATIENT SERVICES

Unless otherwise specified in this Benefit Booklet, services for Outpatient Care are Covered Services when:
- Deemed Medically Necessary; and
- Billed for by a Provider.

Look in the ***Schedule of Covered Services*** section to find how much of those or other costs the Member is required to share (pay).

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 Health Benefit Plan will provide coverage for ambulance services. However, these services need to be:
- Medically Necessary as determined by the Health Benefit Plan; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when 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.

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 transports: Non-Emergency air or ground facility transport may be covered when Medically Necessary as determined by the Health Benefit Plan (For example, 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 an In-Network Facility Provider as determined by the Health Benefit Plan, when:
  - The transfer is Medically Necessary (as determined by the Health Benefit Plan'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 Health Benefit Plan will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for members.

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 (For example, social worker, licensed professional counselor), Physicians, Psychologists, certified nurse practitioners, or psychiatric mental health nurse practitioners, as is consistent with state licensing requirements.

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

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

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

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

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

- 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 Member Services.

Colorectal Cancer Screening

The Health Benefit Plan 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. The method and frequency of screening to be utilized shall be:

- Coverage for Symptomatic Members shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician.
- Coverage for Nonsymptomatic Members over age 50 shall include, but not be limited to:
    - 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 Health Benefit Plan 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 Professional Provider.

Diabetic Education Program
When prescribed by a Professional Provider legally authorized to prescribe such items under law, the Health Benefit Plan 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.

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 an In-Network Provider; and
  - Be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Health Benefit Plan.

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.

Diagnostic Services
The Health Benefit Plan will provide coverage for the following Diagnostic Services, when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:
- Routine Diagnostic Services, including, but not limited to:
  - Routine radiology: Consisting of x-rays, mammograms, ultrasound, and nuclear medicine;
  - Routine medical procedures: Consisting of ECG, EEG and other diagnostic medical procedures approved by the Health Benefit Plan; and
  - Allergy testing: Consisting of percutaneous, intracutaneous and patch tests.
- Non-Routine Diagnostic Services, including, but not limited to:
  - Nuclear Cardiology Imaging;
  - MRI/MRA;
  - CT Scans;
  - PET Scans; and
  - Sleep Studies.
- Diagnostic laboratory and pathology tests.
- 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 Health Benefit Plan, 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 Health Benefit Plan will provide coverage for the rental or, at the option of the Health Benefit Plan, the purchase of Durable Medical Equipment when:
- Prescribed by a Professional Provider and required for therapeutic use; and
- Determined to be Medically Necessary by the Health Benefit Plan.

Although an item may be classified as Durable Medical Equipment it may not be covered in every instance. Durable Medical Equipment, as defined in the ***Important Definitions*** section, that includes equipment that meets the following criteria:
- It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, (That is, the type of item that could normally be rented). Medical Supplies of an expendable nature are not considered "durable" (For example, see the "Non-reusable supplies" provisions of the "Durable Medical Equipment" exclusion of the ***Exclusions - What Is Not Covered*** section of this Program);
- It customarily and primarily serves a medical purpose;
- It is generally not useful to a person without an illness or injury. The item must be expected

to make a meaningful contribution to the treatment of the Member's illness, injury, or to improvement of a malformed body part; and
- It is appropriate for home use.

- Replacement and Repair:
  The Health Benefit Plan 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 Health Benefit Plan 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 Health Benefit Plan 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 Health Benefit Plan.

  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 Health Benefit Plan in the case of rented equipment; and
  - The Member in the case of purchased equipment.

  Breakage during reasonable useful lifetime: The Health Benefit Plan 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 Health Benefit Plan will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.)

  Cost to repair vs. cost to replace: The Health Benefit Plan 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.

Emergency Care Services
- The In-Network level of benefits provided: Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are provided by the Health Benefit Plan. They are provided at the In-Network level of benefits, regardless of whether the Member is treated by an In-Network or Out-of-Network Provider.
- Where to call and where to go: If Emergency Services are required, whether the Member is located in or outside the Personal Choice Network service area: Call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.
- What Emergency Care is: Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency.
- Examples of an Emergency include:
  - Heart attack;
  - Loss of consciousness or respiration;
  - Cardiovascular accident;
  - Convulsions;

- Severe Accidental Injury; and
- Other acute medical conditions as determined by the Health Benefit Plan.

Note: Should any dispute arise as to whether an Emergency existed or as to the duration of an Emergency: The determination by the Health Benefit Plan shall be final.

Home Health Care

- Covered Services: The Health Benefit Plan 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: The Health Benefit Plan will also provide coverage 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 Health Benefit Plan.
- 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 Health Benefit Plan 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.

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

Injectable Medications

The Health Benefit Plan will provide coverage for injectable medications required in the treatment of an injury or illness when administered by a Professional Provider.

- Specialty Drugs
  - Refer 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 logon 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 Identification Card.
– Gene Replacement Therapies are eligible for coverage under the medical benefit and require Precertification 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 Precertification list. This list can be found at: https://www.ibx.com/resources/for-providers/policies-and-guidelines/operations-management/preapproval-requirements.

Coinsurance applies:

- The purchase of all Specialty Drugs is subject to:
  - Coinsurance, if dispensed by an In-Network Provider; or
  - Coinsurance, if dispensed by an Out-of-Network Provider.
- The Coinsurance amounts are shown in the ***Schedule of Covered Services***.

– Coinsurance amounts will apply:

- To each 30 day supply of medication dispensed for medications administered on a regularly scheduled basis; or
- To each course/series of injections if administered on an intermittent basis.

A 90 day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness.

– Dual Coverage

Coverage and costs: The Health Benefit Plan 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 Precertification 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
  - Standard Injectable Drugs refer 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.
  - Standard Injectable Drugs include, but are not limited to:
    - Allergy injections and extractions; and
    - Injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.
  - Self-Administered Prescription Drugs generally are not covered.
  - For more information on Self-Administered Prescription Drugs:
    - Please refer to the ***Exclusions - What Is Not Covered*** section.

Medical Foods and Nutritional Formulas

- The Health Benefit Plan 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 Health Benefit Plan will provide coverage for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment supplier or in connection with Infusion Therapy as provided for in this Program.

An estimated basal caloric requirement for Medical Foods and Nutritional Formula is not required for those with IEMs, or for when administered through a tube.

Non-Surgical Dental Services

The Health Benefit Plan 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. Injury as a result of chewing or biting is not considered an Accidental Injury. See the exclusion of dental services in the ***Exclusions - What Is Not Covered*** section for more information on what dental services are not covered.

Observation Room
The Health Benefit Plan will provide coverage for Observation Room Covered Services, when Medically Necessary as determined by the Health Benefit Plan. Cost-sharing requirements are specified in the ***Schedule of Covered Services***.

Orthotics (Devices Used for Support of Bones and Joints)
The Health Benefit Plan 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 Health Benefit Plan. 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.

Podiatric Care
The Health Benefit Plan will provide coverage for:
- 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 covered.

Prescription Drugs
After each Member satisfies the Deductible amount for the Benefit Period, the Health Benefit Plan will provide coverage for Covered Drugs and medicines prescribed by a Physician and dispensed by a licensed Pharmacy*. Benefits for Prescription Drugs are available for a 30 day supply, or the appropriate therapeutic limit, whichever is less, when dispensed from a retail Pharmacy.

The Health Benefit Plan shall also provide coverage for covered Prescription Drugs (Chronic Drugs) prescribed for a chronic condition and ordered by mail if a Member or the prescribing Physician submits to an In-Network Mail Order Pharmacy a written Prescription Drug Order specifying the amount of the covered Prescription Drug to be supplied. Benefits shall be available for up to a 90 day supply of a covered Chronic Drug, subject to the amount specified in the Prescription Drug Order and applicable law. In addition, benefits shall also be provided for covered Prescription Drugs prescribed by a Physician for a chronic condition and dispensed by a designated retail Pharmacy or a participating Act 207 retail Pharmacy. The cost sharing indicated in the "Prescription Drugs" subsection of the ***Schedule of Covered Services*** section for In-Network Mail Order Pharmacies will apply. Benefits are available for up to a 90-day supply. To verify that a retail Pharmacy is a designated retail Pharmacy or a participating Act 207 Pharmacy, access www.ibx.com.

Deductible amounts apply to Prescription Drugs dispensed by a retail or mail order In-Network or Out-of-Network Pharmacy.

* If the Health Benefit Plan determines Prescription Drug usage by any Member appears to exceed usage generally considered appropriate under the circumstances, the Health Benefit

Plan shall have the right to direct that Member to one Pharmacy for all future Prescription Drug Covered Services.

The Health Benefit Plan will only provide benefits for covered Specialty Drugs through the pharmacy benefits manager's (PBM's) Specialty Pharmacy Program for the appropriate cost sharing indicated in the "Prescription Drugs" subsection of the ***Schedule of Covered Services*** section for In-Network 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".

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

Contraceptives, as described under the Women’s Preventive Services provision of the Patient Protection and Affordable Act, covered under the "Prescription Drugs" section of this Benefit Booklet for certain generic products and brand products approved by the Federal Food and Drug Administration are covered at no cost-share to the Member when obtained from an In-Network Pharmacy or In-Network Mail Order Pharmacy. Coverage includes oral and injectable contraceptives, diaphragms, cervical caps, rings and transdermal patches, emergency contraceptives and certain over-the-counter contraceptive methods. The noted cost-sharing reflected in the "Prescription Drugs" subsection of the ***Schedule of Covered Services*** applies for all other contraceptive products.

For questions concerning pharmaceutical management procedures such as prior authorization requirements, prescription limits, use of generic substitution, therapeutic interchange or step therapy protocols and Deductible, Copayment and Coinsurance amounts, the Member may call the Member Services telephone number referenced on the Member's Identification Card.

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.

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

Prescription Drugs shall mean drugs or medications (including insulin):
- Which by law require a Prescription Order to dispense;
- Which are approved by the Health Benefit Plan and approved for distribution by the federal government;

- For which Medical Necessity exists; and
- Which have been approved by the Federal Food and Drug Administration and only for those uses for which they have specifically been approved by the Federal Food and Drug Administration.

Prosthetic Devices
The Health Benefit Plan will provide coverage for expenses Incurred for Prosthetic Devices (except dental prostheses) required as a result of illness or injury. Expenses for Prosthetic Devices are subject to medical review by the Health Benefit Plan to determine eligibility and Medical Necessity.

Such expenses may include, but not be limited to:
- The purchase, fitting, necessary adjustments and repairs of Prosthetic Devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ;
- The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device. Except coverage is not available for enhancements or deluxe supplies or convenience features that do not serve or contribute towards any clinically established physiological and/or functional improvements;
- Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive Surgery incident and subsequent to mastectomy; and
- Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
  - Initial contact lenses prescribed for 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
  - Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of:
    - Accidental Injury;
    - Trauma; or
    - Ocular Surgery.

  The repair and replacement provisions do not apply to this item.

Benefits for replacement of a Prosthetic Device or its parts will be provided:
- When there has been a significant change in the Member's medical condition that requires the replacement;
- If the prostheses breaks because it is defective;
- If the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer; or
- For a Dependent's child due to the normal growth process when Medically Necessary.

The Health Benefit Plan will provide benefits to repair Prosthetic Devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of the prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Health Benefit

Plan will not provide benefits for repairs and replacements needed because the prostheses was abused or misplaced.

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

Specialist Office/Telemedicine Visits
The Health Benefit Plan will provide coverage for Specialist Services Medical Care provided in the office by a Provider other than a Primary Care Provider.

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

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

Spinal Manipulation Services
The Health Benefit Plan 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 Health Benefit Plan will provide coverage, subject to the Benefit Period Maximums specified in the ***Schedule of Covered Services***, for the following services prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority to perform the applicable therapeutic service, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Member.

- Cardiac Rehabilitation Therapy
  Refers to a medically supervised rehabilitation program designed to improve a patient'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:
  - 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 Health Benefit Plan's policies; and
- 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
  The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

- Infusion Therapy
  The infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a Professional 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 Professional 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
  Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

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

- 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.

- Respiratory Therapy
  Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

- 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.

Urgent Care Centers
The Health Benefit Plan will provide coverage for Urgent Care Centers, when Medically Necessary as determined by the Health Benefit Plan.
- 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 Professional Provider or Retail Clinic.

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

Virtual Care Services
- Services Provided by a contracted vendor
  Virtual care services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone or secure video when a Professional Provider is unavailable or inaccessible. These licensed Providers do not replace an existing Professional Provider relationship but enhances it with an efficient, convenient alternative for non-emergency medical problems. The applicable vendor Provider cost-sharing requirements are specified in the ***Schedule of 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 Professional Provider and subject to the relevant cost-share applicable to that Provider. The Provider's eligibility will be determined by the Health Benefit Plan in the Health Benefit Plan's policies, who is licensed in the state where the virtual care service is being offered. Virtual care services are covered when the encounter takes place via a secure Health Insurance Portability and Accountability Act (HIPAA) - compliant interactive audio and video telecommunications system as specified in the Health Benefit Plan's policies.

EXCLUSIONS – WHAT IS NOT COVERED

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

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;
- Qi 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.

Assisted Reproductive Technology
For the following Assisted Reproductive Technology services:
- Injectable Infertility medications;
- Acquisition and storage costs of donor gametes or embryos;
- The costs for ovulation kits;
- Costs related to surrogacy or gestational carrier;
- Services provided to a dependent child;
- Procedures performed on a person who is not a Member;
- Services provided to a Member when the cause of Infertility is vasectomy;
- Services provided to a Member when the cause of Infertility is tubal ligation; and
- The cost of cryopreservation of embryos and charges for storage of sperm.

Autism
- For the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program.
- For the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

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

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
For 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; and
  - Toilet seats.
- The item has features of a medical nature which are not required by the member'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 services and operations for cosmetic purposes
- Which are done to improve the appearance of any portion of the body; and
- From which no improvement in physiologic function can be expected.

However, benefits are payable to correct:
- A condition resulting from an accident; and
- Functional impairment which results from a covered disease, injury or congenital birth defect.

This exclusion does not apply to mastectomy related charges as provided for and defined in the "Surgical Services" section in the ***Description of Covered Services***.

Cranial Prostheses (Including Wigs)
For cranial prostheses, including wigs intended to replace hair.

Day Rehabilitation Program
For Day Rehabilitation Program services.

Dental Care

- 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).

Diagnostic Screening Examinations
For diagnostic screening examinations, except for mammograms and preventive care as provided in the "Primary and Preventive Care", "Women's Preventive Care" and "Diagnostic Services" subsections of the ***Description of Covered Services***.

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 (For example, aducsnumab-avwa)

Delandistrogene moxeparvovec

Tofersen

Exon skipping drugs for Duchenne Muscular Dystrophy (DMD) (For example, Eteplirsen, Golodirsen, Viltolarsen, Casimersen)

Lecanemab-irmb (Leqembi)

Durable Medical Equipment
For the following examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:
- Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.

- Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.
- Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as:
  - Diathermy machines;
  - Medcolator;
  - Data transmission devices used for telemedicine purposes;
  - Pulse tachometer;
  - Translift chairs; and
  - Traction units.
- Non-reusable supplies other than a supply that is an integral part of the Durable Medical Equipment item required for the Durable Medical Equipment function. This means the equipment is not durable or is not a component of the Durable Medical Equipment.
- Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to:
  - Equipment For Safety;
  - Exercise equipment;
  - Speech teaching machines;
  - Strollers;
  - Toileting systems;
  - Electronically-controlled heating and cooling units for pain relief;
  - Bathtub lifts;
  - Stairglides; and
  - Elevators.
- Equipment with features of a medical nature which are not required by the Member's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medical Necessity and realistically feasible alternative item that serves essentially the same purpose.
- Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.
- Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment.
- Modifications to vehicles, dwellings and other structures. This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Member's disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as customization to a wheelchair.

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

Experimental/Investigative
Which are Experimental/Investigative in nature, except, as approved by the Health Benefit Plan, Routine Patient Costs Associated With Qualifying Clinical Trials that meets the definition of a Qualifying Clinical Trial under this Benefit Booklet.

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.

Hearing Aids

For hearing or audiometric examinations, and Hearing Aids and the fitting thereof; and, routine 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 as defined by the Health Benefit Plan, such as, but not limited to:

- Computer Tomography (CT) scanners;
- Magnetic Resonance Imagers (MRI); and
- Linear accelerators.

Unless the acquisition of such equipment by a Professional Provider was approved:

- Through the Certificate of Need (CON) process; and/or
- By the Health Benefit Plan.

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
For Hospice Care benefits for the following:
- Services and supplies for which there is no charge;
- 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);
- Care provided by family members, relatives, and friends; and
- Private Duty Nursing.

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

Immunizations for Employment or Travel
For 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 Behavioral Analysis).

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

Lipedema
For 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;
- 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, and soy-based products. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the "Medical Foods and Nutritional Formulas" section in the ***Description of Covered Services***;
- For elemental semi-solid foods (For example, Neocate Nutra);
- For products that replace fluids and electrolytes (For example, Electrolyte Gastro, Pedialyte);
- For oral additives (For example, Duocal, fiber, probiotics, or vitamins) and food thickeners (For example, Thick-It, Resource ThickenUp); and
- For supplies associated with the oral administration of formula (For example, 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
Which are not Medically Necessary as determined by the Health Benefit Plan for the diagnosis or treatment of illness or injury.

Mental Health/Psychiatric Care
- For vocational or religious counseling; and
- For activities that are primarily of an educational nature.

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 Health Benefit Plan's Medical Policies;
  - Camp, with the exception of behavioral health services specified in the Health Benefit Plan's Medical Policies; or
  - Institution for intellectually disabled children.
- For broken appointments.
- For telephone consultations.
- For completion of a claim form.
- For marriage counseling.
- For Custodial Care, domiciliary care or rest cures.
- Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Service Provider" except as otherwise indicated under the subsections entitled:
  - "Therapy Services"; and
  - "Ambulance Services/Transport" in the ***Description of Covered Services*** section.
- 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; or
  - Evaluations not associated with therapy.

Motor Vehicle
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
Any services, supplies or treatments not specifically listed as covered benefits in this Program.

Obesity
For treatment of obesity, including surgical treatment of obesity and pharmacological drugs for the treatment of obesity management.

This exclusion does not apply to nutrition counseling visits/sessions as described in the "Nutrition Counseling for Weight Management" provision in this Benefit Booklet.

Orthoptic/Pleoptic Therapy
For treatment associated with Orthoptic/Pleoptic Therapy.

Over-The-Counter Drugs
For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient Admission. This exclusion does not apply to over-the-counter medicines that are prescribed by a Physician in accordance with applicable law.

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;
  Wigs;
- Chairlifts;
- Stairglides;
- Elevators;
- Sauna;
- Television;
- Spa or health club memberships;
- Whirlpool;
- 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 (Drug Program)
- Drugs used for Experimental or Investigative purposes;
- Drugs used for cosmetic purposes, such as wrinkle removal or hair growth;
- Health foods, dietary supplements, or pharmacological therapy for weight reduction or diet agents;
- Vitamins, unless they require a prescription and are Medically Necessary for the treatment of a specific illness, as determined by the Health Benefit Plan;
- Prescription Drugs for which there is an equivalent that does not require a Prescription Drug Order, (That is, over-the-counter medicines). This exclusion does not apply to insulin or over-the-counter medicines that are prescribed by a Physician in accordance with applicable law and certain drugs that are specifically designated by the Health Benefit Plan;
- For Convenience Pack drugs which combine two or more individual drug products into a single package with a unique national drug code.
- Drugs which have no currently accepted medical use for treatment in the United States;
- Drugs dispensed to a Member while a patient in a Hospital, nursing home or other institution;
- Injectable drugs, including Infusion Therapy drugs that are covered under the Group's medical plan;
- Smoking deterrent agents. This exclusion does not apply to prescribed smoking deterrent agents;
- Administration or injection of drugs;
- Injectables used for treatment of infertility when they are prescribed solely to enhance or facilitate conception;
- Devices of any type, even though such devices may require a Prescription Order. This includes, but is not limited to therapeutic devices or appliances, hypodermic needles, syringes or similar devices. This exclusion does not apply to:
  - Devices used for the treatment or maintenance of diabetic conditions, such as glucometers and syringes used for the injection of insulin;
  - Devices known as metered dose inhalers that are used to enhance the effectiveness of inhaled medicines; and
  - Contraceptive devices as mandated by the Women’s Preventive Services provision of the Patient Protection and Affordable Act;
- Drugs obtained through mail order prescription drug services; and
- Drugs obtained through mail order prescription drug services of an Out-of-Network Mail Order Pharmacy; and
- Prescription Drugs not approved by the Health Benefit Plan or prescribed drug amounts exceeding the eligible dosage limits established by the Health Benefit Plan.

Prescription Drugs (Medical Program)
- For Prescription Drugs, except as may be provided under the "Prescription Drugs" section of the ***Description of Covered Services***. This exclusion does NOT apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels, as provided for the treatment of diabetes.
- For drugs and medicines for which the Member has coverage under a free-standing prescription drug program provided through the Enrolled Group.

Private Duty Nursing
For Inpatient and Outpatient Private Duty Nursing services.

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" sections of the ***Description of Covered Service*s**.

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.

Reversal of a Sterilization
For any Surgery performed for the reversal of a sterilization procedure.

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.

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

This exclusion does not apply to Self-Administered Prescription Drugs that are:
- 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 Free-Standing Prescription Drug Contract issued to the Group by the Health Benefit Plan; or
- Required for treatment of an Emergency condition that requires a Self-Administered Prescription Drug.

Sexual Dysfunction
For 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 in a Skilled Nursing Facility 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 treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension.

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.

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

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
- For correction of myopia or hyperopia by means of corneal microsurgery, such as:
  - Keratomileusis;
  - Keratophakia;
  - Radial keratotomy and all related services.
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses except as otherwise described in this Benefit Booklet.

Weight Reduction
Pharmacological drugs for weight reduction.

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 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 this Program and described in this Benefit Booklet. If a person becomes an eligible person after the Group's Effective Date, that date becomes the eligible person's effective date under this Program.

Eligible Person
The Employee is eligible to be covered under this Program if the Employee is determined by the Group as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by the Employee's physical condition and determination of eligibility for the coverage by the employer shall be final and binding.

Eligible Dependent
The Employee's family is eligible for coverage (Dependent coverage) under this Program when the Employee is eligible for Employee coverage. An eligible Dependent is defined as the Employee's spouse under a legally valid existing marriage, the Employee's child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is the Employee's responsibility 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.

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 this Program 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 Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):
- Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
- Notifying the Health Benefit Plan that the Dependent is no longer on active duty; or
- 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 Domestic Partner is also eligible for enrollment. 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 Health Benefit Plan 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 direct pay coverage of the type for which the former Domestic Partner and children are then qualified, at the rate then in effect. This direct pay coverage may be different from the coverage provided under this Benefit Booklet.

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 Employee for over half of their support. The Health Benefit Plan may require proof of eligibility under the prior Health Benefit Plan's plan and also from time to time under this Program.

The newborn child(ren) of the Employee or the Employee's Dependent shall be entitled to the benefits provided by this Program 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 Employee 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 Employee must apply within 31 days after the birth of the newborn and the appropriate rate, calculated from the 32nd day after birth, must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under this Program on the date the Dependent is acquired provided that the Employee applies to the Health Benefit Plan for addition of the Dependent within 31 days after the Dependent is acquired and the Employee 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 Employee's Application is accepted by the Health Benefit Plan.

A Dependent child of a custodial parent covered under this Program may be enrolled under the terms of a qualified medical release or court order, as required by law.

No Dependent may be eligible for coverage as a Dependent of more than one Member of the Enrolled Group. No individual may be eligible for coverage hereunder as a Member and as a Dependent of a Member at the same time.

Benefits to Which the Member Is Entitled
The liability of the Health Benefit Plan is limited to the benefits specified in this Benefit Booklet. The Health Benefit Plan's determination of the benefit provisions applicable for the services rendered to the Member shall be conclusive.

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 Health Benefit Plan before the Health Benefit Plan 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 Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Group notified the Health Benefit Plan of such termination.

Consumer Rights
Each Member has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call Member Services at the toll-free number referenced on the Identification Card.

Member/Provider Relationship
- The choice of a Provider is solely the Member's choice.
- The Health Benefit Plan does not furnish Covered Services but only makes payment for Covered Services received by persons covered under this Program. The Health Benefit Plan is not liable for any act or omission of any Provider. The Health Benefit Plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

COVERAGE CONTINUATION

Termination of the Member's Coverage and Conversion Privilege Under This Program
- Termination of this Program - Termination of the Group coverage (this Program) automatically terminates all coverage for the Member (an Enrolled Employee) and the Member's eligible Dependents. The privilege of conversion to a conversion contract shall be available to any Member who has been continuously covered under the Contract for at least three months (or covered for similar benefits under any group plan that this Program replaced).

  It is the responsibility of the Group or the Group's Applicant Agent to notify the Member and the Member's eligible Dependents of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

  Rescission: If it is proven that the Member or the Member's eligible Dependent obtained or attempted to obtain benefits or payment for benefits, through fraud or intentional misrepresentation of material fact, the Health Benefit Plan, may, upon notice to the Member, terminate the coverage. The Member will receive written notice at least 30 days prior to termination but will have the right to utilize the ***Appeal of an Administrative Denial and Medical Necessary Appeal Process*** to appeal cancellation.

  The privilege of conversion is available for the Member and the Member's eligible Dependents except in the following circumstances:
  - The Group terminates this Program in favor of group coverage by another organization; or
  - The Group terminates the Member in anticipation of terminating this Program in favor of group coverage by another organization.

- Notice of Conversion - Written notice of termination and the privilege of conversion to a conversion contract shall be given within 15 days before or after the date of termination of this Program, provided that if such notice is given more than 15 days but less than 90 days after the date of termination of this Program, the time allowed for the exercise of the

privilege of conversion shall be extended for 15 days after the giving of such notice. Payment for coverage under the conversion contract must be made within 31 days after the coverage under this Program ends. Evidence of insurability is not required. Upon receipt of this payment, the conversion contract will be effective on the date of the Member's termination under this Program.

Conversion coverage shall not be available if the Member is eligible for another health care program which is available in the Group where the Member is employed or with which the Member is affiliated to the extent that the conversion coverage would result in over-insurance.

If the Member's coverage or the coverage of the Member's eligible dependent terminates because of the Member's death, the Member's change in employment status, divorce of dependent spouse, or change in a dependent's eligibility status, the terminated Member will be eligible to apply within 31 days of termination (or termination of the continuation privileges under COBRA) to conversion coverage, of the type for which that Member is then qualified at the rate then in effect. This conversion coverage may be different from the coverage provided under this Program. Evidence of insurability is not required.

Continuation Of Coverage At Termination Of Employment Or Membership Due To Total Disability

The Member's protection under this Program may be extended after the date the Member ceases to be a Member under this Program because of termination of employment or membership in the Group. It will be extended if, on that date, the Member is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the Member remains Totally Disabled from any such illness or injury, but not beyond 12 months if the Member ceases to be a Member because the Member's coverage under this Program ends.

Coverage under this Program will apply during an extension as if the Member was still a Member. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for the Member through the Health Benefit Plan by the Group. Continuation of coverage is subject to payment of the applicable premium.

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 (an enrolled Employee) for over half of the child's support, the Member may apply to the Health Benefit Plan to continue coverage of such child under this Program upon such terms and conditions as the Health Benefit Plan 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 child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 26 years of age. 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 26 years of age and joining the Health Benefit Plan for the first time, the handicapped child must have been covered under the prior Health Benefit Plan and submit proof from the prior Health Benefit Plan that the child was covered as a handicapped person.

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.

When The Employee Terminates Employment - Continuation Of Coverage Provisions 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.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify that person 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:

- A covered Employee;
- The Employee's spouse; or
- The Employee's Dependent child.

In addition, any child born to or placed for adoption with the Employee 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 Employee during Mini-COBRA continuation, will not be a qualified beneficiary.

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

  The continuation will cover the Employee and any other qualified beneficiary who loses coverage because of the Employee'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 Employer's Responsibilities: The Employee's employer must notify the Employee, the plan administrator, and the Health Benefit Plan, in writing, of:
  - The Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
  - The Employee's death;
  - The Employee's divorce or legal separation from an eligible dependent;
  - The Employee becomes eligible for benefits under Social Security;
  - The Employee's dependent child ceases to be a dependent child pursuant to the terms of the group health benefits Benefit Booklet;
  - Commencement of Employer's bankruptcy proceedings.

The notice must be given to the Employee, the plan administrator and the Health Benefit Plan 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 administrator or its designee of their election of continuation coverage within 30 days of receipt of the Notice from the Employer.

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

  Upon receipt of the Employee's, or the Employee's eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

- If an Employee Dies: If the covered Employee 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 an Employee's Marriage Ends: If the Employee'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 Employee's Dependent child's group health benefits end due to the Dependent's loss of dependent eligibility as defined in this Benefit Booklet, other than the Employee's coverage ending, the Dependent 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 Continuation Ends" paragraph of this subsection.

- Election of Continuation: To continue the qualified beneficiary's group health benefits, the qualified beneficiary must give the plan administrator written notice that the qualified beneficiary elects to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of the qualified beneficiary's continuation rights from the plan administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Health Benefit Plan 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 plan administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the plan 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 benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to 5% of the total premium charge may also be required by the Health Benefit Plan.

- 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 ends on the first to occur of the following:
  - With respect to continuation upon the Employee'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 Employee's death, the Employee's legal divorce or legal separation, or the end of the Employee'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 Employee's Dependent whose continuation is extended due to the Employee'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 the qualified beneficiary becomes 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 the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
  - The date the Employee and/or eligible dependent become eligible for Medicare.

THE HEALTH BENEFIT PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BENEFIT BOOKLET.

THE HEALTH BENEFIT PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

INFORMATION ABOUT PROVIDER REIMBURSEMENT

The Member's Personal Choice Network Plan (this Program) is a program, which allows the Member to maximize the Member's health care benefits by utilizing the Personal Choice Network, which is comprised of Providers that have a contractual arrangement with the Health Benefit Plan. These Providers are called "In-Network Providers". In-Network Providers are doctors, Hospitals and other health care professionals and institutions that are part of the Personal Choice Network, which is designed to provide access to care through a selected managed network of Providers. Services by In-Network Providers are delivered through a selected, managed network of Providers designed to provide quality care. The Personal Choice Network includes Hospitals, Primary Care Physicians and specialists, and a wide range of Ancillary Service Providers, including suppliers of Durable Medical Equipment, Hospice care and Home Health Care Agencies, Skilled Nursing Facilities, Free Standing Dialysis Facilities and Ambulatory Surgical Facilities.

When the Member receives health care through a Provider that is a member of the Personal Choice Network, the Member incurs lower out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if the Member chooses to receive health care through a

Provider that is not an In-Network Provider. However, the level of benefits will be reduced, and the Member will be responsible for a greater share of out-of-pocket expenses, and the amount of the Member's expenses could be substantial. The Member may have to reach a Deductible before receiving benefits, and the Member may be required to file a claim form.

A directory of the In-Network Providers who belong to the Personal Choice Network is available to the Member upon request. It will identify the Professional Providers who have agreed to become In-Network Professional Providers and will also identify the Hospitals in the Network with which the In-Network Professional Providers are affiliated. Also included in the directory is a listing of the Ancillary Service Providers affiliated with the Personal Choice Network. The directory is updated periodically throughout the year, and the Health Benefit Plan reserves the right to add or delete Physicians and/or Hospitals at any given time. It is important to know that continued participation of any one doctor, Hospital or other Provider cannot be guaranteed. For information regarding Providers that participate in the Personal Choice Network, call 1-800-ASK BLUE (TTY: 711).

The Health Benefit Plan covers only care that is "Medically Necessary". Medically Necessary care is care that is needed for the Member's particular condition and that the Member receives at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and Hospital Outpatient Care.

Some of the services the Member receives through this Program must be Precertified before the Member receives them, to determine whether they are Medically Necessary. Failure to Precertify services to be provided by an Out-of-Network Provider, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews the Medically Necessary of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective. Precertification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an Inpatient setting, in many different settings - such as an Outpatient department of a Hospital or a doctor’s office.

When the Member seeks medical treatment that requires Precertification, the Member is not responsible for obtaining the Precertification if treatment is provided by an In-Network Provider (That is, a Provider in the Personal Choice Network). In addition, if the In-Network Provider fails to obtain a required Precertification of services, the Member will be held harmless from any associated financial Penalties assessed by the Program as a result. If the request for Precertification is denied, the Member will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If the Member decides to continue treatment or care that has not been approved, the Member will be asked to do the following:

- Acknowledge this in writing.
- Request to have services provided.
- State the Member's willingness to assume financial liability.

When the Member seeks treatment from an Out-of-Network Provider or a BlueCard Provider (excluding Inpatient Admissions), the Member is responsible for initiating the Precertification process. The Member or the Member's Provider should call the Precertification number listed on the Member's Identification Card, and give their name, facility’s name, diagnosis, and procedure or reason for admission. Failure to Precertify required services will result in a reduction of benefits payable to the Member.

Payment Of Providers

- In-Network Provider Reimbursement

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

  Please note that these programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If the Member has any questions about how the Member's health care Provider is compensated, the Member should speak to their healthcare Provider directly or contact Customer Services.

  - Physicians

    Personal Choice Network Physicians, including Primary Care Provider (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Health Benefit Plan's Personal Choice fee schedule for the specific medical services that the Physician performs.

  - Institutional Providers

    Hospitals: For most Inpatient medical and surgical 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 the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, (For example, transplants). For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

    The Health Benefit Plan implemented a quality incentive program with a few Hospitals. This program provides increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

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

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

  - Physician Group Practices, Physician Associations and Integrated Delivery Systems

    Certain Physician group practices, independent physician associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with individual Physicians to provide medical services. These groups are paid as described in the Physician’s reimbursement section outlined above. These

groups may pay their affiliated Physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

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

- Pharmacy
  A pharmacy benefits management company (PBM) administers our Prescription Drug benefits, and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. The Health Benefit Plan 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 Health Benefit Plan 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.

- Payment of Out-of-Network Providers
  For Covered Services received from an Out-of-Network Provider when the Consolidated Appropriations Act ("CAA") does not apply to the Covered Services, payment will be made directly to the Member and the Member will be responsible for reimbursing the Out-of-Network Provider. However, Health Benefit Plan reserves the right, in its sole discretion, to make payments directly to the Out-of-Network Provider. For Covered Services that fall within the scope of the CAA, payment will be made directly to the Out-of-Network Provider in accordance with the provisions of the CAA.

- Payment Methods
  A Member or the Provider may submit bills directly to the Health Benefit Plan, and, to the extent that benefits are payable within the terms and conditions of this Benefit Booklet, reimbursement will be furnished as detailed below. The Member's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet.

  - Facility Providers
    - In-Network Facility Providers
      In-Network Facility Providers are members of the Personal Choice Network and have a contractual arrangement with the Health Benefit Plan for the provision of services to Members. Benefits will be provided as specified in the ***Schedule of Covered***

Services for Covered Services which have been performed by an In-Network Facility Provider. The Health Benefit Plan will compensate In-Network Facility Providers in accordance with the contracts entered into between such Providers and the Health Benefit Plan. BlueCard Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Member for Covered Services rendered by any In-Network Facility Provider.

- Out-of-Network Facility Providers

  Out-of-Network Facility Providers include facilities that are not part of the Personal Choice Network. The Health Benefit Plan may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network.

  The Health Benefit Plan will provide benefits for Covered Services provided by an Out-of-Network Facility Provider at the Out-of-Network Coinsurance level specified in the ***Schedule of Covered Services***. The reimbursement rate is specified under "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet.

  If the Health Benefit Plan determines that Covered Services were for Emergency Care as defined herein, the Member is protected from surprise billing or balance billing. 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 right under the CAA not to be balanced billed for these post-stabilization services. Emergency admissions must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Health Benefit Plan. Payment for Emergency Services provided by Out-of-Network Providers will be based upon the methodology established by the CAA.

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

– Professional Providers
  - In-Network Providers

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

    Benefit amounts, as specified in the ***Schedule of Covered Services*** of this Program, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the In-Network Professional Provider and a Member with respect to balance billing shall be submitted to the Health Benefit Plan for determination. The decision of the Health Benefit Plan shall be final.

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

- Emergency Care by Out-of-Network Providers
  If the Health Benefit Plan determines that Covered Services provided by an Out-of-Network 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. Penalties that ordinarily would be applicable to Out-of-Network Covered Services will not be applied. For Emergency Care and other Out-of-Network Providers, such as ambulance and air ambulance services, the Health Benefit Plan will reimburse the Out-of-Network Provider directly for Covered Services based upon the methodology established by the 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 right under the CAA not to be balanced billed for these post-stabilization services. For payment of Covered Services provided by an Out-of-Network Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by the Health Benefit Plan. Payment for Emergency Services provided by Out-of-Network Providers will be based upon the methodology established by the CAA.

- Out-of-Network Hospital-Based Provider Reimbursement
  When the Member receives Covered Services from an Out-of-Network Hospital-Based Provider while the Member is an Inpatient at an In-Network Hospital or other In-Network Facility Provider and are being treated by an In-Network Professional Provider, the Member will receive the In-Network cost-sharing level of benefits for the Covered Services provided by the Out-of-Network Hospital-Based Provider. For Covered Services outside the scope of the CAA, payment will be made to the Member, who will be responsible for reimbursing the Out-of-Network Hospital-Based Provider. For Covered Services within the scope of the CAA, the Health Benefit Plan will reimburse the Out-of-Network Hospital-Based Provider directly based upon the methodology established by the CAA. The Member cannot be balanced billed by the Out-of-Network Hospital-Based Provider, and the Out-of-Network Hospital-Based Provider cannot ask the Member to give up their right under the CAA not to be balanced billed. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet. Payment for services provided by Out-of-Network Hospital-Based Providers will be based upon the methodology established by the CAA.

  If the Member receives other services at an In-Network Hospital or other In-Network Facility Provider, Out-of-Network Providers cannot balance bill the Member, unless the Member gives written consent and gives up the right under the CAA not to be balanced billed.

  Note that when the Member elects to see an Out-of-Network Hospital-Based Provider for follow-up care or any other service where the Member has the ability to select an In-Network Provider and the CAA does not apply to the Covered Service,

the Covered Services will be covered at an Out-of-Network benefit level. Except for Emergency Care, if an Out-of-Network Provider admits the Member to a Hospital or other Facility Provider, Covered Services provided by an Out-of-Network Hospital-Based Provider will be reimbursed at the Out-of-Network benefit level. For such Covered Services, payment will be made to the Member and the Member will be responsible for reimbursing the Out-of-Network Hospital-Based Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet.

- Inpatient Hospital Consultations by an Out-of-Network Professional Provider
  When the Member receives Covered Services for an Inpatient hospital consultation from an Out-of-Network Professional Provider while the Member is Inpatient at an In-Network Facility Provider, and the Covered Services are referred by an In-Network Professional Provider, the Member will receive the In-Network cost-sharing level of benefits for the Inpatient hospital consultation. The Health Benefit Plan will reimburse the Out-of-Network Professional Provider at an In-Network rate directly. For certain Out-of-Network Hospital-Based Providers (For example, anesthesiologists, hospitalists and other Providers as defined by the CAA), the Health Benefit Plan will reimburse the Out-of-Network Hospital-Based Provider directly based upon the methodology established by the CAA. For certain Providers, the Member cannot be balanced billed by the Out-of-Network Professional Provider, and the Out-of-Network Professional Provider cannot ask the Member to give up their right under the CAA not to be balanced billed.

  For such Covered Services not within the scope of the CAA, payment will be made to the Member and the Member will be responsible for reimbursing the Out-of-Network Professional Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet. For Covered Services within the scope of the CAA, payment for consultation services provided by Out-of-Network Professional Providers will be made directly to the Provider based upon the methodology established by the CAA.

  The Out-of-Network Professional Provider cannot balance bill the Member, unless the Member gives written consent and gives up the right under the CAA not to be balanced billed.

  Note that when the Member elects to see an Out-of-Network Professional Provider for follow-up care or any other service when the Member has the ability to select an In-Network Provider, and the CAA does not apply to the Covered Service, the Covered Services will be covered at an Out-of-Network benefit level. Except for Emergency Care and other Covered Services within the scope of the CAA, if an Out-of-Network Professional Provider admits the Member to a Hospital or other Facility Provider, services provided by Out-of-Network Professional Provider will be reimbursed at the Out-of-Network benefit level. For such Covered Services, payment will be made to the Member and the Member will be responsible for reimbursing the Out-of-Network Professional Provider. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet.

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

- Out-of-Network Professional Provider Reimbursement
  Except as set forth above, when a Member seeks care from an Out-of-Network Professional Provider, benefits will be provided to the Member at the Out-of-Network Coinsurance level specified in the ***Schedule of Covered Services***. For payment of Covered Services provided by an Out-of-Network Professional Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet. When a Member seeks care and receives Covered Services from an Out-of-Network Professional Provider, the Member will be responsible to reimburse the Out-of-Network Professional Provider for the difference between the Health Benefit Plan's payment and the Out-of-Network Professional Provider's charge.

– Ancillary Service Providers
  - In-Network Ancillary Service Providers
    In-Network Ancillary Service Providers include members of the Personal Choice Network that have a contractual relationship with the Health Benefit Plan for the provision of services or supplies to Members. Benefits will be provided as specified in the ***Schedule of Covered Services*** for the provision of services or supplies provided to Members by In-Network Ancillary Service Providers. The Health Benefit Plan will compensate In-Network Ancillary Service Providers in the Personal Choice Network in accordance with the contracts entered into between such Providers and the Health Benefit Plan. No payment will be made directly to the Member for Covered Services rendered by any In-Network Ancillary Service Provider.

  - Out-of-Network Ancillary Service Providers
    Out-of-Network Ancillary Service Providers are not members of the Personal Choice Network. Benefits will be provided to the Member at the Out-of-Network Coinsurance level specified in the ***Schedule of Covered Services***. The Member will be penalized by the application of higher cost-sharing as detailed in the ***Schedule of Covered Services***. For payment of Covered Services provided by an Out-of-Network Ancillary Service Provider, please refer to the definition of "Covered Expense" in the ***Important Definitions*** section of this Benefit Booklet. When a Member seeks care and receives Covered Services from an Out-of-Network Ancillary Service Provider, the Member will be responsible to reimburse the Out-of-Network Ancillary Service Provider for the difference between the Health Benefit Plan's payment and the Out-of-Network Ancillary Service Provider's charge.

– Pharmacies
  - In-Network Pharmacies
    With respect to In-Network Pharmacies, benefits will be provided as specified in the ***Schedule of Covered Services*** for the provision of In-Network services or supplies for Prescription Drugs.

The Health Benefit Plan will compensate In-Network Pharmacies in accordance with the agreements in effect with respect to services or supplies provided to Members. No payment will be made directly to the Member for Covered Services rendered by any In-Network Pharmacy.

- Out-of-Network Pharmacies
  With respect to Out-of-Network Pharmacies, benefits will be provided to the Member at the Out-of-Network Coinsurance level specified in the ***Schedule of Covered Services*** for Prescription Drugs.

  Any applicable cost-sharing (such as Deductible and Coinsurance amounts) specified in the ***Schedule of Covered Services*** for Prescription Drugs will be applied to the Covered Expense amount. The Member will be penalized by the application of a higher Coinsurance level as detailed in the ***Schedule of Covered Services*** for Prescription Drugs. An Out-of-Network Pharmacy is entitled to collect from the Member any cost-sharing obligation and the remaining balance due.

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

BlueCard Program

- Out-of-Area Services

  Overview

  Independence Assurance Company ("IAC") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever the Member accesses healthcare services outside of the geographic area IAC serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

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

  Inter-Plan Arrangements Eligibility - Claim Types

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

– BlueCard® Program
Under the BlueCard® Program, when the Member receives Covered Services within the geographic area served by a Host Blue, IAC will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When the Member receives Covered Services outside IAC's service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services is calculated based on the lower of:
- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to IAC.

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 past pricing of claims, as noted above. However, such adjustments will not affect the price IAC has used for the Member's claim because they will not be applied after a claim has already been paid.

– Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

– Nonparticipating Providers Outside IAC's Service Area

- Member Liability Calculation
  When Covered Services are provided outside of IAC's service area by nonparticipating providers, the amount the Member pays for such services will normally be based on either the Host Blue’s nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment IAC will make for the

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

- Exceptions
  In certain situations, IAC may use other payment methods, such as billed charges for Covered Services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount IAC will pay for services provided by nonparticipating providers. In these situations, the Member may be liable for the difference between the amount that the nonparticipating provider bills and the payment IAC will make for the Covered Services as set forth in this paragraph.

– Blue Cross Blue Shield Global Core

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

If the Member needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

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

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

SERVICES AND SUPPLIES REQUIRING PRECERTIFICATION

Precertification Review

When required, Precertification review 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 planned or elective Inpatient Admissions and selected Outpatient procedures. For groups located in the Personal Choice Network service area, Precertification review may be initiated by the Provider or the Member depending on whether the Provider is a Personal Choice Network Provider. For Member's located outside the Health Benefit Plan's Personal Choice Network who are accessing BlueCard Providers, the Member is responsible for initiating or requesting the Provider to initiate the Precertification review (excluding Inpatient Admissions). Where Precertification review is required, the Health Benefit Plan's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for Medical Necessity of the requested procedure setting (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 review is not required for Emergency services and is not performed where an agreement with the Health Benefit Plan's local In-Network Provider does not require such review.

The following information provides more specific information of this Program's Precertification requirements.

- Inpatient Pre-Admission Review
  - In-Network Inpatient Admissions
    In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Health Benefit Plan as to the Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this ***General Information*** section. An In-Network Hospital, Skilled Nursing Facility, or other Facility Provider in the Personal Choice Network will verify the Precertification at or before the time of admission. The Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard Program. The Health Benefit Plan will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if Precertification is required and is not obtained in advance. For Member's who reside in the Health Benefit Plan's local Personal Choice Network service area, the Health Benefit Plan will hold the Member harmless and the Member will not be financially responsible for admissions to Hospitals, Skilled Nursing Facilities or other Facility Providers in the Personal Choice Network which fail to conform to the pre-admission certification requirements unless:
    - The Provider provides prior written notice that the admission will not be paid by the Health Benefit Plan; and
    - The Member acknowledges this fact in writing together with a request to be admitted which states that the Member will assume financial liability for such Facility Provider admission.

- Out-of-Network Inpatient Admissions
  For an Out-of-Network Inpatient Admission, the Member is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.
  - To obtain Precertification, the Member is responsible to contact or have the admitting Physician or other Facility Provider contact the Health Benefit Plan prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Health Benefit Plan will notify the Member, admitting Physician and the Facility Provider of the determination. The Member is eligible for Inpatient benefits at the Out-of-Network level shown in the ***Schedule of Covered Services*** if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this Benefit Booklet.
  - If such prior approval for a Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown below, will be deemed not to be Covered Services under this Program. Such Penalty, and any difference in what is covered by the Health Benefit Plan and the Member's obligation to the Provider, will be the sole responsibility of, and payable by, the Member.

    If a Member elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Member will be financially liable for non-covered Inpatient charges.
  - If Precertification is denied, the Member, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Member, Physician, or Facility Provider will be so notified.

- <u>Emergency Admission Review</u>
  - In-Network Admissions
    It is the responsibility of the In-Network Provider to notify the Health Benefit Plan of the In-Network Emergency admission.

  - Out-of-Network Provider Admissions
    - Members are responsible for notifying the Health Benefit Plan of an Out-of-Network Provider Emergency admission within two business days of the admission, or as soon as reasonably possible, as determined by the Health Benefit Plan.
    - Failure to initiate Emergency admission review will result in a reduction in Covered Expense for Out-of-Network services. Such Penalty, as shown below, will be the sole responsibility of, and payable by, the Member.
    - If the Member elects to remain hospitalized after the Health Benefit Plan and the attending Physician have determined that an Inpatient level of care is not Medically Necessary, the Member will be financially liable for non-covered Inpatient charges from the date of notification.

- <u>Concurrent and Retrospective Review</u>
  Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. When performed, the review assesses the level of care provided to the Member and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent Review is generally not performed where an Inpatient

Facility is paid based on a per case or diagnosis-related basis, or where an agreement with the Facility does not require such review.

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

In addition to these standard utilization reviews, the Health Benefit Plan also may determine coverage of certain procedures and other benefits available to Members through Prenotification as required by the Member's benefit plan, and discharge planning.

Pre-notification. Pre-notification is advance notification to the Health Benefit Plan of an Inpatient Admission or Outpatient service where no Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Members for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Members 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 benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Health Benefit Plan's authorization of covered post-Hospital services and identifying and referring Members to Disease Management or Case Management benefits.

Selective Medical Review. In addition to the foregoing requirements, the Health Benefit Plan 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 Health Benefit Plan reserves the right to waive medical review for certain Covered Services for certain Providers, if the Health Benefit Plan determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services. Coverage penalties are not applied to Members where required Selective Medical Review is not obtained by the Provider.

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

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

- In-Network Care
  In-Network Providers in the Personal Choice Network must contact the Health Benefit Plan to initiate Precertification. The Health Benefit Plan will verify the results of the Precertification

with the Member and with the In-Network Provider. If the In-Network Provider is a BlueCard Provider, however, the Member must initiate Precertification (excluding Inpatient Admissions).

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

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

- Out-of-Network Care
  For Out-of-Network Care and care provided by BlueCard Providers (excluding Inpatient Admissions), the Member is responsible to have the Provider performing the service contact the Health Benefit Plan to initiate Precertification. The Health Benefit Plan will verify the results of the Precertification with the Member and the Provider.

  If such prior approval is not obtained and the Member undergoes the surgical, diagnostic or other procedure or treatment that requires Precertification, then benefits will be provided for Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty, as reflected below. Such Penalty, and any difference in what is covered by the Health Benefit Plan and the Member's obligation to the Provider, will be the sole responsibility of, and payable by, the Member.

Precertification Penalty:
If the Provider is a BlueCard Provider of another Blue Plan (excluding Inpatient Admissions) or the Member uses an Out-of-Network Provider, the Member must obtain Precertification if required. The Member will be subject to a 20% reduction in benefits if Precertification is not obtained.

In addition to the Precertification requirements referenced above, the Member should contact the Health Benefit Plan for certain categories of treatment (listed below) so that the Member will know prior to receiving treatment whether it is a Covered Service. This applies to In-Network Providers in the Personal Choice Network and to Members (and their Providers) who elect to receive treatment provided by either BlueCard Providers or Out-of-Network Providers. Those categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic;
- Any procedure, treatment, drug or device that represents "emerging technology"; and
- Services that might be considered Experimental/Investigative.

The Member’s Provider should be able to assist in determining whether a proposed treatment falls into one of these three categories. Also, the Health Benefit Plan encourages the Member’s Provider to place the call for the Member.

For more information, please see the ***Important Notices*** section of this Benefit Booklet that pertain to Experimental/Investigative Services, Cosmetic services, Medically Necessary services and Emerging Technology.

Disease Management and Decision Support Programs

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

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

The Health Benefit Plan will utilize medical information such as claims data to operate the Disease Management or Decision Support program, (For example, to identify Members with chronic disease, to predict which Members would most likely benefit from these services, and to communicate results to the Member's treating Physician(s)). The Health Benefit Plan will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Member in Disease Management or Decision Support programs is voluntary. A Member may continue in the Disease Management or Decision Support program until any of the following occurs:

- The Member notifies the Health Benefit Plan that they have declined participation; or
- The Health Benefit Plan determines that the program, or aspects of the program, will not continue.
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Out-Of-Area Care for Dependent Students

If an unmarried Dependent child is a full-time student in an Accredited Educational Institution located outside the area served by the Personal Choice Network, the student may be eligible to receive Out-of-Network care at the In-Network level of benefits. Charges for treatment will be paid at the In-Network level of benefits when the Dependent student receives care from Providers as described in the "BlueCard Program" subsection of the ***General Information*** section. However, treatment provided by an educational facility's infirmary for Urgent Care, (For example, may also be paid at the In-Network level of benefits, but the Health Benefit Plan should be notified within 48 hours of treatment to insure Covered Services are treated as In-Network Covered Services). Nothing in this provision will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under this Program.

UTILIZATION REVIEW PROCESS AND CRITERIA

Utilization Review Process

A basic condition of IBC's, and its subsidiary Independence Assurance Company's ("the Health Benefit Plan") benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Necessary. To assist the Health Benefit Plan in making coverage determinations for requested health care services, the Health Benefit Plan uses

established IBC 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 Health Benefit Plan to be Medically Necessary and automatically approved based on the accepted Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an Emergency room which has been approved by the Health Benefit Plan 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 it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Health Benefit Plan follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval using the Health Benefit Plan's Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Health Benefit Plan may deny coverage for a procedure based on Medical Necessity. The evidence-based clinical protocols evaluate the Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable benefit plan policies and procedures, taking into consideration 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 Health Benefit Plan's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing Physicians with direct access to the Health Benefit Plan's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external Physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Health Benefit Plan 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.

Clinical Criteria, Guidelines and Resources

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

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Health Benefit Plan in determining Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff evaluating the Medical Necessity of coverage based on a Member's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Health Benefit Plan's plan determinations for similar medical issues and requests, and reduces practice variation among the Health Benefit Plan'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 hospitalizations;
- Inpatient Rehabilitation;
- Home Health;
- Durable Medical Equipment;
- Skilled Nursing Facility.

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

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

Covered Services for which IBC's Medical Polices are applied include, but are not limited to:

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

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

Delegation of Utilization Review Activities And Criteria

In certain instances, the Health Benefit Plan has delegated certain utilization review activities, including Precertification review, concurrent review, and Case Management, to integrated delivery systems and/or entities with an expertise in medical management of a certain membership population (such as, Neonates/premature infants) or type of benefit or service (such as mental health/psychiatric care and Alcohol and Drug Abuse or radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Health Benefit Plan's approval.

Utilization Review and Criteria for Mental Health/Psychiatric Care and Alcohol and Drug Abuse Services

Utilization Review activities for mental health/psychiatric care and Alcohol and Drug Abuse services have been delegated by IBC (and IAC) to a behavioral health management company,

which administers the mental health/psychiatric care and Alcohol and Drug Abuse benefits for the majority of the Health Benefit Plan's Members.

COORDINATION OF BENEFITS

Coordination of Benefits

This Program's Coordination of Benefits (COB) provision is designed to conserve funds associated with health care.

- Definitions
  In addition to the Definitions of this Program for purposes of this provision only:
  "Plan" shall mean any group arrangement providing health care benefits or Covered Services through:
  - Individual, group, (except hospital indemnity plans), blanket (except student accident) or franchise insurance coverage;
  - The Plan, health maintenance organization and other prepayment coverage;
  - Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
  - Coverage under any tax supported or government program to the extent permitted by law.

- Determination of Benefits
  COB applies when an Employee has health care coverage under any other group health care plan (Plan) for services covered under this Program, or when the Employee has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between the Health Benefit Plan and the other Plan in order to avoid duplication of benefits.

  Benefits under this Program will be provided in full when the Health Benefit Plan is primary, that is, when the Health Benefit Plan determines benefits first. If another Plan is primary, the Health Benefit Plan will provide benefits as described below.

  When an Employee has group health care coverage under this Program and another Plan, the following will apply to determine which coverage is primary:
  - If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.
  - If the other Plan includes rules for coordinating benefits:
    - The Plan covering the patient other than as a Dependent shall be primary.
    - The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary.
    - Except as provided in the following paragraph, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
      - First, the Plan covering the child as a Dependent of the parent with custody;
      - Then, the Plan of the spouse of the parent with custody of the child;
      - Finally, the Plan of the parent not having custody of the child.
    - When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such

financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.
    - If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in the paragraph that begins "The Plan covering the patient as a Dependent...".
  - The Plan covering the patient as an Employee who is neither laid off nor retired (or as that Employee's Dependent) is primary to a Plan which covers that patient as a laid off or retired Employee (or as that Employee's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
  - If none of the above rules apply, the Plan which covered the Employee longer shall be primary.

- Effect on Benefits
  When the Health Benefit Plan's Plan is secondary, the benefits under this Program will be reduced so that the Health Benefit Plan will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Program and the total Covered Services provided to the Employee. Benefits payable under another Plan include benefits that would have been payable had the claim been duly made therefore. In no event will the Health Benefit Plan payment exceed the amount that would have been payable under this Program if the Health Benefit Plan were primary.

  When the benefits are reduced under the primary Plan because an Employee does not comply with the Plan provision, or does not maximize benefits available under the primary Plan, the amount of such reduction will not be considered an allowable benefit. Examples of such provisions are Penalties and increased Coinsurance related to Precertification of admissions and services, In-Network Provider arrangements and other cost-sharing features.

  Certain facts are needed to apply COB. The Health Benefit Plan has the right to decide which facts are needed. The Health Benefit Plan 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 Health Benefit Plan deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Health Benefit Plan such information as may be necessary to implement this provision. The Health Benefit Plan, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Program shall be affected by the benefits that would be payable under any and all other Plans only to the extent that the Health Benefit Plan is furnished with information relative to such other Plans.

- Right of Recovery
  Whenever payments which should have been made under this Program in accordance with this provision have been made under any other Plan, the Health Benefit Plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits provided under this Program and, to the extent of such payments, the Health Benefit Plan shall be fully discharged from liability under this Program.

Whenever payments have been made by the Health Benefit Plan in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Health Benefit Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Health Benefit Plan shall determine:

- The person the Health Benefit Plan has paid or for whom they have paid;
- Insurance companies; or
- Any other organizations.

The Member, on the Member's own behalf and on behalf of the Member's Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to the Health Benefit Plan.

SUBROGATION AND REIMBURSEMENT RIGHTS

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.

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.

CLAIM PROCEDURES

How To File A Claim

The Member is never required to file a claim when Covered Services are provided by In-Network Providers. When the Member receives care from an Out-of-Network Provider, the Member will need to file a claim to receive benefits. If the Member does not have a claim form, the Member should call the Health Benefit Plan's Member Services Department at the number listed on the Member's Identification Card, and a claim form will be sent to the Member. The Member should fill out the claim form and return it with their itemized bills to the Health Benefit Plan at the address listed on the claim form no later than 20 days after completion of the Covered Services. The claim should include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was 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 Health Benefit Plan be required to accept the claim more than 12 months after the end of the Benefit Period in which the Covered Services are 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 Health Benefit Plan, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Health Benefit Plan may furnish similar information to other entities providing similar benefits at their request.

The Health Benefit Plan may furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

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

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 Services are rendered.

Claim Forms
The Health Benefit Plan will furnish to the Member or to the Group, for delivery to the Member, such claim forms as are required for filing proof of loss for Covered Services provided by Out-of-Network Providers.

Timely Filing
The Health Benefit Plan will not be liable under this Program unless proper notice is furnished to the Health Benefit Plan that Covered Services have been rendered to a Member. Written notice must be given within 90 days after completion of the Covered Services. The notice must include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Health Benefit Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Health Benefit Plan be required to accept notice more than 12 months after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by In-Network Providers.

Time of Payment of Claims
Claim payments for benefits payable under this Program will be processed immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all benefits for loss for which this Program provides periodic benefits will be paid not more than 30 days after receipt of proof of loss and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims
If any indemnity of this Program 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.

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

this Program; 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.

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 (For example, obtaining Precertification, use of In-Network Providers), or to the administration of this Program by the Health Benefit Plan, the Health Benefit Plan 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 Health Benefit Plan 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 Health Benefit Plan nor the Providers in the Health Benefit Plan's PPO network shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances as recognized in the community, and by the Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:
- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot;
- Civil insurrection; or
- Public health emergency.

APPEAL OF AN ADMINISTRATIVE DENIAL AND MEDICAL NECESSITY APPEAL PROCESS

Informal Member Complaint Process
The Health Benefit Plan has a process for Members to request an informal Complaint. To register an informal Complaint, Members should call the Member Services Department at the telephone number on their Identification Card or write to the Health Benefit Plan at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this stage. If the Health Benefit Plan cannot immediately resolve the Member’s concern, the Health Benefit Plan will acknowledge it in writing within **five business days** of receiving the request. The Member will receive a response within 30 calendar days. If the Member is not satisfied with the response to their concern from the Health Benefit Plan, the Member has the right to file a formal appeal through the Member’s Appeal of an Administrative Denial process described below.

Authorizing Someone to Represent the Member
At any time, the Member may choose a third party to be their representative in their Member appeal such as a Provider, lawyer, relative, friend, another individual, or a person who is part of an organization. The law states that the Member's written authorization or consent is required in

order for this third party called an "authorized representative" to pursue an appeal on the Member's behalf. An authorized representative may make all decisions regarding the Member's appeal, provide and obtain correspondence, and authorize the release of medical records and any other information related to their appeal. In addition, if the Member chooses to authorize an appeal representative, the Member has the right to limit their authority to release and receive the Member's medical records or other appeal information in any other way the Member identifies.

To authorize someone to be the Member's authorized representative, the Member must complete valid authorization forms. The required forms are sent to adult Members or to the parents, guardians, or other legal representatives of minor or incompetent Members who appeal and indicate that they want an authorized representative to appeal on their behalf. Authorized representative forms can be obtained by calling or writing to the address listed below:

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

Except in the case of an expedited appeal, the Health Benefit Plan must receive completed, valid authorization forms before the Member's appeal can be processed. (For information on expedited appeals, see the definition below and the references in the Appeal of an Administrative Denial Process and the Medical Necessity Appeal Process sections below.) The Member has the right to withdraw or rescind authorization of an authorized representative at any time during the process.

If the Member's Provider files an appeal on the Member's behalf, the Health Benefit Plan will verify that the Provider is acting as the Member's authorized representative with their permission by obtaining valid authorization forms. A Member who authorizes the filing of an appeal by a Provider cannot file a separate appeal.

Information for the Appeal Review:

How to File and Get Assistance
Appeals may be submitted by the Member or their authorized representative with the Member's authorization by following the steps outlined below in the descriptions of the Appeal of an Administrative Denial and the Medical Necessity Appeal Process. At any time during these appeal processes, the Member may request the help of a Health Benefit Plan employee in preparing or presenting their appeal; this assistance will be available at no charge. Please note that the Health Benefit Plan employee designated to assist the Member will not have participated in the previous decision to deny coverage for the issue in dispute and will not be a subordinate of the original reviewer.

Full and Fair Review
The Member or authorized representative is entitled to a full and fair review. Specifically, at all appeal levels the Member or authorized representative may submit additional written comments, records or other information pertaining to the case, to the Health Benefit Plan. The Health Benefit Plan takes into account all information submitted by the Member, whether such information was submitted or considered during the initial Adverse Benefit Determination or prior level of review. The Health Benefit Plan documents when the Member fails to submit relevant information by the specified deadline. The Member or authorized representative may specify the remedy or corrective action being sought. At the Member’s or authorized

representative's request, the Health Benefit Plan will provide access to and copies of all relevant documents, records, and other information (excluding the Health Benefit Plan's confidential, proprietary, or privileged information). The Health Benefit Plan will automatically provide the Member or authorized representative with any new or additional evidence considered, relied upon, or generated by the Health Benefit Plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or authorized representative at no charge.

Advance Notice
The Health Benefit Plan will not terminate or reduce an-ongoing course of treatment without providing the Member or authorized representative with advance notice and the opportunity for advanced review.

Urgent Care
In the appeal context, Urgent Care is medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Members with Urgent Care conditions or who are receiving an on-going course of treatment may request an internal expedited appeal and also proceed with an expedited external review at the same time.

Changes in Member Appeals Processes
Please note that the Member appeals processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Member appeals processes, or to reflect other decisions regarding the administration of Member appeals processes for this Program.

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

Appeal Classifications
Appeals of an Administrative Denial and Medical Necessity Appeals, established by Pennsylvania state laws and regulations, are described in detail in separate sections below.

An Appeal of an Administrative Denial may be filed to challenge a denial based on a contract limitation, prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy, certain surprise medical bills received by a Member from an Out-of-Network Provider, rescissions of coverage (except for failure to pay premiums or coverage contributions) or to complain about other aspects of health plan policies or operations that has not been resolved by the Health Benefit Plan and has been filed with the Pennsylvania Insurance Department (PID).

A Medical Necessity Appeal may be filed when the denial of a covered service is based

primarily on Medical Necessity, Experimental/Investigative exclusions, or cosmetic exclusions.

You may question the classification of your appeal as an Appeal of an Administrative Denial or Medical Necessity Appeal by contacting the Health Benefit Plan's Member Appeals Department or your assigned appeals specialist at the address and telephone number shown above or by contacting the Pennsylvania Insurance Department at:

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

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

Appeals are also subject to the following classifications:

A **pre-service appeal** is any appeal for benefits with a coverage requirement that preapproval or Precertification by the Health Benefit Plan must be obtained before Medical Care and services are received.

A **post-service appeal** includes any appeal regarding benefits for Medical Care or services that a Member has already received or any appeal for a service that does not require preapproval or Precertification by the Health Benefit Plan.

Internal Standard Appeal of an Administrative Denial
The Member or authorized representative may file an Appeal of an Administrative Denial for an unresolved dispute or objection. The Appeal of an Administrative Denial process consists of two internal levels of review by the Health Benefit Plan, and one external level of review by the Pennsylvania Insurance Department.

Internal Standard First Level Appeal of an Administrative Denial-
The Member or authorized representative may file an internal standard first level Appeal of an Administrative Denial **within 180 calendar days** from either their receipt of the original notice or the completion of the **Informal Member Complaint Process** described above. To file an internal standard first level Appeal of an Administrative Denial, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

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

The Member or authorized representative may submit an oral or written appeal. Additionally, The Member or authorized representative may submit written data or other information to the Health Benefit Plan for consideration regarding the appeal. The Health Benefit Plan will acknowledge receipt of the Member's Appeal of an Administrative Denial in writing.

The internal standard first level Appeal of an Administrative Denial is decided by a Health Benefit Plan employee who has no previous involvement with the case and who is not the

subordinate of anyone previously involved with the case. The decision notification is sent to the Member or authorized representative within:

- **15 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal.

If the Member's appeal is denied, the decision letter states:

- The specific reason for the decision;
- This Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to appeal to the next level if the Member is not satisfied with the decision.

Internal Standard Second Level Appeal of an Administrative Denial

If the Member or authorized representative is not satisfied with the decision from their first level Appeal of an Administrative Denial, they may file an internal standard second level appeal to the Second Level Appeal of an Administrative Denial Committee **within 60 calendar days** of their receipt of the First Level Committee's decision from the Health Benefit Plan. To file a second level appeal, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

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

Upon receipt of the Member's appeal, the Member or authorized representative will be notified in writing in advance of a date and time scheduled for the Internal Standard Second Level Appeal of an Administrative Denial Committee meeting. The Member or authorized representative may request a change in the meeting schedule. The Health Benefit Plan will do its best to accommodate their request while remaining within the established timeframes. If the Member or authorized representative does not participate in the meeting, the Second Level Committee will review their Appeal of an Administration Denial and make its decision based on all available information.

The Second Level Appeal of an Administrative Denial Committee meets and renders a decision on the Member's standard appeal and notifies the Member or authorized representative within:

- **15 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal.

The Internal Standard Second Level Appeal of an Administrative Denial Committee is composed of at least three persons who have had no previous involvement with the Member's case and who are not subordinates of the person who made the original determination. The Second Level Appeal of an Administrative Denial Committee members will include the Health Benefit Plan's staff, with one third of the Committee being other persons who are not employed by the Health Benefit Plan. The Member or authorized representative may submit supporting materials both before and at the appeal meeting. Additionally, the Member or authorized representative has the right to review all information considered by the Committee that is not the Health Benefit Plan's confidential, or privileged information.

The Internal Standard Second Level Appeal of an Administrative Denial Committee meeting is a forum where Members have an opportunity to present their issues via a video conference or conference call in an informal setting that is not open to the public. Members of the press may only participate in their personal capacity as the Member's authorized representative or to

provide general, personal assistance. Members, authorized representatives, and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Member/authorized representative will be sent the decision letter of the Internal Standard Second Level Appeal of an Administrative Denial Committee on their appeal **within five business days** of the date the decision is made. The notice will include the basis for the denial and the procedure for appealing the decision to the Pennsylvania Insurance Department's Bureau of Health Care Access, Administration and Appeals (HCA3) or the Bureau of Consumer Affairs. The Member may be represented by an attorney or other individual in the state review. The decision is final unless the Member chooses to appeal to the Pennsylvania Insurance Department as described in the decision letter. (See also **External Appeal of an Administrative Denial** below.)

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

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

The Member's request for external review of an Appeal of an Administrative Denial should include the Member's name, address, daytime telephone number, the name of the Health Benefit Plan as their health care plan, the group number, the Member's Health Benefit Plan ID number and a brief description of the issue being appealed. Also include a copy of the Member's original request for an internal second level standard appeal review to the Health Benefit Plan and copies of any correspondence and decision letters from the Health Benefit Plan.

When an external Appeal of an Administrative Denial request is submitted to the Pennsylvania Insurance Department's HCA3 or Bureau of Consumer Services, the original submission date of the request is considered the date of receipt. The regulatory agency that receives the request will review it and transfer it to the other agency if this is found to be appropriate. The regulatory agency that handles the Member's external appeal will provide the Member and the Health Benefit Plan with a copy of the final determination of its decision.

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

Internal Standard Medical Necessity Appeal Process

Member Appeal Process for Decisions Based on Medical Necessity

Members/authorized representatives may file a formal Medical Necessity Appeal of a decision by the Health Benefit Plan regarding a Covered Service that was denied or limited based primarily on Medical Necessity, the cosmetic or Experimental/Investigative exclusions, or other grounds that rely on a medical or clinical judgment (including appropriateness, health care setting and level of care or effectiveness).

The appeal process consists of one internal review by the Health Benefit Plan and if appealed further, an external review conducted by an accredited private Independent Review Organization (IRO). The external review is coordinated by the Pennsylvania Insurance Department's HCA3. There is also an internal and external expedited Medical Necessity Appeal

process in the event the Member's condition involves an urgent issue.

The Member or authorized representative may file an internal standard Medical Necessity Appeal **within 180 calendar days** from the date of receipt of the original denial by the Health Benefit Plan. To do so, call Customer Service at the toll-free telephone number listed on their ID Card, or call, write or fax the Member Appeals Department as follows:

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

The Health Benefit Plan will acknowledge receipt of the Member's Medical Necessity Appeal in writing. This confirmation advises that the Health Benefit Plan considers the matter to be a Medical Necessity Appeal and that the Member or authorized representative may question the classification by contacting the HCA3. or the Bureau of Consumer Services at the information listed above.

The Member's one level of internal appeal is reviewed by a Health Benefit Plan Medical Director, who is the decision-maker. This individual holds an active unrestricted license to practice medicine, has had no previous involvement in the case, and is not a subordinate of the person who made the original determination. Additionally, the Health Benefit Plan Medical Director is a same or similar specialist, or the decision-maker receives input from an independent consultant who is a same or similar specialist. A same or similar specialist or "same or similar specialty Physician" is a licensed Physician or Psychologist who is in the same or similar specialty as typically manages the case under review. Additionally, the physician consultant:

- Has had no previous involvement in the case;
- Is not a subordinate of the person who makes the original determination;
- Is not a subordinate of anyone previously involved with the case.

If the same or similar specialist Physician is a consultant, their opinion on the Medical Necessity Appeal issues will be reported to the Health Benefit Plan in writing for consideration. The Member or authorized representative may request a copy of the same or similar specialist's opinion in writing, and it will be provided to the Member or authorized representative prior to the date of review by the Health Benefit Plan Medical Director. The same or similar specialist's report includes their credentials as a licensed Physician or Psychologist such as board certification.

The Health Benefit Plan Medical Director completes the review of the Member's standard appeal and sends notification to the Member or authorized representative within:

- **30 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal;
- **72 hours** from receipt of a standard non-formulary exception appeal request.

The Member or authorized representative will be sent the decision on their internal appeal in writing **within five business days** of the determination. If the Member's Medical Necessity Appeal is denied, the decision letter states:

- The specific reason for the denial;
- The Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to request an external review if the Member is not satisfied with the decision.

Internal Expedited Medical Necessity Appeals

If the Member's case involves an Urgent Care condition, then the Member or their Physician (or authorized representative) may ask to have the Member's case reviewed in a faster manner, as an Expedited Medical Necessity Appeal. The Health Benefit Plan also grants an expedited Medical Necessity Appeal review for all requests concerning admissions, continued stay or other health care services for a Member who has received Emergency services but has not been discharged from a facility. There is one internal level of appeal review for an Expedited Medical Necessity appeal.

Members with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an Internal Expedited Medical Necessity Appeal review by the Health Benefit Plan, call Customer Service at the toll-free telephone number listed on the Member's ID card, or call, or fax the Member Appeals Department at the telephone numbers listed above. The Health Benefit Plan will promptly inform the Member whether their appeal request qualifies for expedited review or instead will be processed as a standard Medical Necessity Appeal.

The decision process for an Internal Expedited Medical Necessity Appeal mirrors the one described above for the Internal Standard Medical Necessity Appeal.

The Internal Expedited Medical Necessity Appeal review is completed promptly based on the Member's health condition. The Health Benefit Plan conducts an expedited internal review and issues a decision to the Member, authorized representative, and Practitioner/Provider **within 72 hours** of the date the Health Benefit Plan receives the appeal. For non-formulary exception requests, the appeal is decided, and notification sent **within 24 hours** of receipt of the request. The notification includes the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

EXTERNAL REVIEW INDEPENDENT REVIEW ORGANIZATION (IRO) PROCESS

External Appeal Process For Decisions Based On Medical Necessity, Experimental/Investigative Treatment, Cosmetic Issues, Certain Surprise Medical Bills Received by Members From Out-of-Network Providers, and Recissions of Coverage (except for non-payment of premiums or coverage contributions).

The Member or authorized representative may file a written request for an external appeal with the HCA3 **within four months** of the receipt of the Health Benefit Plan's Adverse Benefit Determination or final Adverse Benefit Determination for an internal Medical Necessity Appeal. The HCA3 contracts directly with the IRO and notifies the Health Benefit Plan of the assignment for each case file. The HCA3 is also responsible for keeping IRO pricing at a reasonable level. The Member or authorized representative does not pay any of the cost for an external review.

Please refer to the final internal appeal Adverse Benefit Determination letter for specific instructions on how to file the appeal with the HCA3.

A Member/authorized representative may only request an external review after exhausting the Health Benefit Plan's internal appeal process. The Member/authorized representative shall be deemed to have exhausted the Health Benefit Plan's internal appeal process in the following circumstances:

- The Member/authorized representative has filed a Medical Necessity Appeal.

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

Preliminary Review of an External Review Request

The HCA3 will send a copy of the external review request to the Health Benefit Plan **within one business day** of receipt of the request. **Within five business days** of the Health Benefit Plan's receipt of this copy, the Health Benefit Plan will perform a preliminary review to determine whether:

- The individual is or was a Member under the health insurance policy at the time the health care service was requested, or in the case of a retrospective utilization review, at the time the health care service was provided.
- The health care service that is the subject of the external review request is covered under the Member's health insurance policy, except for determinations by the Health Benefit Plan that a health care service is not covered because it does not meet the Health Benefit Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
- The Member has exhausted the Health Benefit Plan's internal Medical Necessity Appeal process.
- The Member has not provided all required information and forms to process an external review.

For an external review of denial of coverage of an Experimental/Investigative treatment, the Health Benefit Plan's preliminary review will also include a determination of whether:

- The health care service is covered under the Member's health insurance policy, except for the Health Benefit Plan's determination that the health care service is Experimental/Investigative for a particular condition.
- The health care service is not explicitly listed as an excluded benefit under the Member's health insurance policy.
- The Member's treating health care Provider has certified that one of the following situations is applicable:
  - Standard health care services have not been effective in improving the condition of the Member.
  - Standard health care services are not medically appropriate for the Member.
- There are no available standard health care services under the health insurance policy that are more beneficial than the recommended or requested health care services described in the next paragraph.
- The Member's treating health care Provider either:
  - Has recommended health care services that the health care Provider certifies, in writing, are more likely to be beneficial to the Member, in the health care Provider's opinion, than available standard health care services.
  - Has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care services requested by the Member who is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination, are likely to

be more beneficial to the Member than any available standard health care services, when the treating health care Provider is a licensed, board-certified or board-eligible Physician qualified to practice in the area of medicine appropriate to treat the Member's condition.

External Review Process

Within one business day of completion of the preliminary review, the Health Benefit Plan notifies the HCA3, the Member/authorized representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the Health Benefit Plan notifies the Member/authorized representative and HCA3 in writing, including what information or materials are needed to make the request complete.
- If the request is not eligible for an external review, the Health Benefit Plan informs the Member/authorized representative and the HCA3 in writing, including the reason(s) why the request is not eligible.
  - The Member/authorized representative may appeal the Health Benefit Plan's initial determination that the external review request is ineligible for review to the HCA3.
  - Despite the Health Benefit Plan's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the Health Benefit Plan and the Member and may be appealed to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

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

The HCA3 sends written notification to the Member/authorized representative of the eligibility of the request based on the preliminary review and of the name and contact information of the assigned IRO. Additionally, the HCA3 notifies the Member/authorized representative they may send the IRO additional information **within 15 business days** of receipt of the HCA3's notification. **Within one business day** of receiving additional information from the Member/authorized representative, the IRO sends a copy of the information to the Health Benefit Plan.

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

Reconsideration by the Health Benefit Plan

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

An external review may be terminated without an IRO determination if the Health Benefit Plan overturns their decision that is the subject of the external review and provides coverage or payment for the recommended health care service that is the subject of the external review.

Within one business day of deciding to overturn their decision, the Health Benefit Plan will notify the HCA3, IRO, and the Member/authorized representative in writing of its decision. The assigned IRO will terminate the external review upon receipt of this notice.

Standard External Review IRO Decision

The assigned IRO decides the appeal and sends notification to the Member/authorized representative **within 45 calendar days** of receipt of the external review request. For an external review of Experimental/Investigative treatment, the assigned IRO makes a decision and sends notification to the Member/authorized representative **within 20 calendar days** of receipt of the external review of the Experimental/Investigative treatment request. For non-formulary exception requests, the IRO makes a decision and sends notification **within 72 hours** of receipt of the request.

Upon receipt of an IRO overturn decision, the Health Benefit Plan will approve the request that was the subject of the external review **within 24 hours**.

Expedited External Review

The Member or authorized representative may make an oral or written request to the HCA3 for an expedited external review. A retrospective case is not eligible for an expedited external review.

Please refer to the final internal appeal Adverse Benefit Determination letter for specific instructions on how to file the appeal with the HCA3.

A Member/authorized representative may request an expedited external review in the following circumstances:

- The Member has an Urgent Care condition for which the time for a standard external review decision would seriously jeopardize the life, or health of the Member or jeopardize their ability to regain maximum function.
- The final Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which a Member receives Emergency Care but has not been discharged from a facility.

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

- The Member has an Urgent Care condition for which the timeframe for completion of an expedited internal review of the Adverse Benefit Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.
- The final Adverse Benefit Determination involves a determination that the recommended or requested health care service is Experimental/Investigative, and the Member's treating health care Provider certifies in writing that the recommended or requested health care service that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Preliminary Review of an Expedited External Review Request

Upon receipt of an expedited external review, the HCA3 sends a copy of the request to the Health Benefit Plan **within 24 hours**.

- **Within 24 hours** of receipt of the request from the HCA3, the Health Benefit Plan determines if the request meets the requirements for an external review and notifies the HCA3 and Member/authorized representative of the Health Benefit Plan's eligibility determination.
  - The Member/authorized representative may appeal the Health Benefit Plan's initial

determination that the external review request is ineligible for review to the HCA3.

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

Expedited External Review Process

Upon receipt of the Health Benefit Plan's notification that the request meets the eligibility requirements, the HCA3 assigns an IRO to conduct the expedited external review **within 24 hours**.

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

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

Expedited External Review IRO Decision

Within 72 hours of receipt of the request, the IRO makes their decision and notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan. For non-formulary exception requests, the IRO makes their decision **within 24 hours** of the request and notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan.

Upon receipt of an IRO overturn decision, the Health Benefit Plan will approve the request that was the subject of the expedited external review **within 24 hours**.

Binding Decision for External Reviews

An IRO decision is binding on the Health Benefit Plan except to the extent the Health Benefit Plan has other remedies available under applicable state law. An IRO decision is binding on the Member/authorized representative, except to the extent the Member/authorized representative has other remedies available under applicable Federal and state laws.

Neither the Member or the authorized representative may file a subsequent request for an external review involving an Adverse Benefit Determination or final Adverse Benefit Determination for which the Member has already received a decision for the same Adverse Benefit Determination or final Adverse Benefit Determination.

If the Member's Health Benefit Plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the Member's appeal, the Member may have the right to bring civil action under Section 502(a) of the Act. For questions about the Member's rights, or for assistance, the Member can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) (TTY: 711). Additionally, a consumer assistance program may be able to assist the Member at:

Pennsylvania Insurance Department
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388 (TTY: 711)
www.insurance.pa.gov

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 rescission of health insurance coverage (when, in connection with the rescission, there is an adverse effect on a particular benefit at that time). An Adverse Benefit Determination may be any of the following:
- A determination by the Health Benefit 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 Health Benefit Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/Investigative, 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 Health Benefit 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 Health Benefit Plan.

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.

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 Health Benefit Plan.

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:
- 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.

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 Health Benefit 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 Health Benefit Plan and did not result in the filing of an Appeal of an Administrative Denial (written or oral).

Applicant And Employee/Member
You, the Employee who applies for coverage under the Program.

Application And Application Card
The request of the Applicant for coverage:
- Either written or via electronic transfer; and
- Set forth in a format approved by the Health Benefit Plan.

Assisted Reproductive Technology
Treatment of Infertility when received or provided under the direction of a Physician.

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

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

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

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 Health Benefit Plan. A charge shall be considered Incurred on the date the service or supply was provided to the Member.

Birth Center
A Facility Provider approved by the Health Benefit Plan which:
- Is primarily organized and staffed to provide maternity care;
- Is where a woman 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 allows a Member travelling or living outside of their plan's area to receive coverage for services at an "In-Network" benefit level if the Member receives services from Blue Cross Blue Shield providers that participate in the BlueCard Program.

BlueCard Provider
A Provider that participates in the BlueCard Program as an In-Network Provider.

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.

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

Case Management
Comprehensive Case Management programs serve 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.

Chronic Drugs
A covered Prescription Drug recognized by the Health Benefit Plan for the treatment of chronic or long term conditions including, but not limited to, cardiac disease, hypertension, diabetes, lung disease and arthritis. The term "Chronic Drugs" shall also mean the following diabetic supplies that may not require a Prescription Order: insulin syringes, diabetic blood testing strips and lancets.

Cognitive Rehabilitation Therapy
Cognitive rehabilitation is 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 the Covered Expense for Covered Services (such as 20%). The Coinsurance percentage is listed in the ***Schedule of Covered Services***.

It is the amount that the Member is obliged to pay for covered medical services, after the Member has satisfied any Copayment(s) or Deductible(s) required by this Program.

Compendia
Compendia are reference documents used by the Health Benefit Plan 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 Health Benefit Plan only reviews current Compendia when making coverage decisions.

Complaint
Any expression of dissatisfaction, verbal or written, by a Member.

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 requiring a Prescription Order to be dispensed for the use of contraception. These include oral contraceptives, such as birth control pills as well as injectable contraceptive drugs.

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

Copayment
A type of cost-sharing in which the Member pays a flat dollar amount each time a Covered Service is provided (such as a $10 or $15 Copayment per office visit). Copayments, if any, are identified in the ***Schedule of Covered Services***.

Covered Drug
Prescription Drugs, including Self-Administered Prescription Drugs, which are:

- Prescribed for a Member by a Professional Provider 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 Health Benefit Plan.

Insulin shall be considered a Covered Drug where Medically Necessary.

Covered Expense
Refers to the basis on which a Member's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

- For Covered Services provided by a Facility Provider, the term "Covered Expense" means the following:

- For Covered Services provided by an In-Network Facility Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Health Benefit Plan.
- For Covered Services provided by an Out-of-Network Facility Provider, "Covered Expense" for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Facility Provider's charges for Covered Services.
- For Covered Services provided by an Out-of-Network Facility Provider, "Covered Expense" for Inpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by the applicable Health Benefit Plan's proprietary fee schedule for the closest analogous Covered Service.

- For Covered Services provided by a Professional Provider, "Covered Expense" means the following:
  - For Covered Services by an In-Network Professional Provider or BlueCard Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with the Health Benefit Plan, or the BlueCard Provider;
  - For an Out-of-Network Professional Provider, "Covered Expense" means the lesser of the Medicare Professional Allowable Payment or of the Provider's charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Professional Provider's charges for Covered Services.
- For Covered Services provided by an Ancillary Service Provider, "Covered Expense" means the following:
  - For Covered Services provided by an In-Network Ancillary Service Provider or BlueCard Provider "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with the Health Benefit Plan or BlueCard Provider.
  - For Covered Services provided by an Out-of-Network Ancillary Service Provider, "Covered Expense" means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the Health Benefit Plan's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Health Benefit Plan's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Out-of-Network Ancillary Service Provider's charges for Covered Services.
- For Covered Services rendered by Pharmacies, "Covered Expense" means the following:

- For Covered Services rendered by an In-Network Pharmacy, the amount that the Health Benefit Plan has negotiated to pay the In-Network Pharmacy as total reimbursement for a Covered Prescription Drug.
- For Covered Services rendered by an Out-of-Network Pharmacy, the lesser of the Out-of-Network Pharmacy's billed charge for the Covered Prescription Drug, or 150% of the average wholesale price for the same Covered Prescription Drug.

- Nothing in this section shall be construed to mean that the Health Benefit Plan would provide coverage for services other than Covered Services.

Covered Service
A service or supply specified in this Benefit Booklet for which benefits will be provided by the Health Benefit Plan.

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 Provider's treatment plan. Some examples of support services are:
- Major treatment choices; and
- Every day health choices.

Deductible
A specified amount of Covered Expense for the Covered Services that is Incurred, by the Member, before the Health Benefit Plan will assume any liability.
- A specific dollar amount that the Member's Health Benefit Plan may require that the Member pay out-of-pocket each Benefit Period, before the Program begins to make payments for claims.

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 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 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, 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 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.

Drug Formulary
A list of 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.

Durable Medical Equipment (DME)
Equipment that meets the following criteria:
- It is durable. (That is, an item that can withstand repeated use.)
- It is medical equipment. (That is, equipment that is primarily and customarily used for medical purposes, and is not generally useful in the absence of illness or injury.)
- It is generally not useful to a person without an illness or injury.
- 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 Health Benefit Plan.

Emergency

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

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

Emergency Care
Covered Services and supplies provided to a Member in, or for, an Emergency:

- By a Hospital or Facility Provider and/or Professional Provider; and
- On an Outpatient basis; and
- In a Hospital Emergency Room or Outpatient Emergency Facility.

Employee
An individual of the Group contracting with the Health Benefit Plan and:

- Who meets the eligibility requirements for enrollment; and
- Who, at enrollment, is specified as meeting the eligibility requirements; and
- In whose name the Identification Card is issued.

Equipment For Safety
Equipment used to keep people safe.

These are:

- Items that are not primarily used for the diagnosis, care or treatment of disease or injury.
- Items which are primarily used to prevent injury or provide a safe surrounding.

Examples include:

- Restraints;
- Safety straps;
- Safety enclosures; and
- Car seats.

Essential Health Benefits
A set of health care service categories that must be covered by certain plans in accordance with the Affordable Care Act. 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 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, device, medical treatment or procedure, or diagnostic test 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 (For example, 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 test 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, 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 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, 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 (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 Health Benefit Plan 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.

Family Coverage
Coverage purchased for the Member and one or more of the Member's Dependents.

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 Health Benefit Plan.

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

Generic Drug
Any form of a particular drug which is:
- Sold by a manufacturer other than the original patent holder;
- Approved by the Federal Food and Drug Administration as 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 Health Benefit Plan, consisting of all those Applicants whose charges are remitted by the Applicant's Agent together with all the Employees, listed on the Application Cards or amendments thereof, who have been accepted by the Health Benefit Plan.

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.

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 shown above:

- A child;
- An unlicensed driver; or
- An individual who cannot drive.

Home Health Care Provider
A Facility Provider, approved by the Health Benefit Plan, that is engaged in providing, either directly or through an arrangement, health care services to Members:

- On an intermittent basis in the Member's Home.
- In accordance with an approved home health care Plan Of Treatment.

Hospice
A Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals.

The Hospice must be:
- 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.

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 Benefit 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;
  - Place for treatment of pulmonary tuberculosis;
  - Place for provision of Hospice care.

Hospital-Based Provider
A Physician who provides Medically Necessary services in a Hospital or other In-Network 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 In-Network 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 Health Benefit Plan.

When these Physicians provide services other than in the Hospital or other In-Network Facility, they are not considered Hospital-Based Providers.

Identification Card (ID Card)

The currently effective card issued to the Member by the Health Benefit Plan which must be presented when a Covered Service is requested.

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 (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.

Infertility
The condition of a healthy Member who is unable to conceive or produce conception after a one year period of unprotected exposure to sperm.

In-Network Ancillary Service Provider
An Ancillary Service Provider that is:
- A member of the Personal Choice Network or is a BlueCard Provider; and
- Has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Members.

In-Network Facility Provider
A Facility Provider that is:
- A member of the Personal Choice Network or is a BlueCard Provider; and
- Has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Members.

In-Network Mail Order Pharmacy
A Pharmacy that is a member of the Health Benefit Plan's pharmacy benefits manager's network and has agreed to a rate of reimbursement determined by contract to provide Members with mail order prescription drug services.

In-Network Pharmacy
A Pharmacy that is a member of the Health Benefit Plan's pharmacy benefits manager's network and has agreed to a rate of reimbursement determined by contract for Prescription Drugs provided to Members.

In-Network Professional Provider
A Professional Provider that is:
- A member of the Personal Choice Network or is a BlueCard Provider; and
- Has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Members.

In-Network Provider
A Facility Provider, Professional Provider, Ancillary Service Provider or Pharmacy that is:
- A member of the Personal Choice Network or is a BlueCard Provider; and
- Authorized to perform specific "in-network" Covered Services at the In-Network level of benefits.

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 For Alcohol Or Drug Abuse And Dependency
The provision of medical, nursing, counseling or therapeutic services 24 hours a day in a Hospital or Non-Hospital Facility, according to individualized treatment plans.

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.

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.

Limiting Age For Dependents
The age at which a child is no longer eligible as a Dependent under the Member's coverage. The Limiting Age for covered children is shown in the ***General Information*** section.

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.

Managed Care Organization (MCO)
A generic term for any organization that manages and controls medical service.

It includes:
- HMOs;
- PPOs;
- Managed indemnity insurance programs; and
- Managed Blue Cross or Blue Shield programs.

Master's 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/Psychiatric Services (including treatment of Serious Mental Illness).

Maximum
A limit on the amount of Covered Services that a Member may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance and Copayment amounts paid by Members for the Covered Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Health Benefit Plan to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.
- Benefit Maximum - the greatest amount of a specific Covered Service that a Member may receive.
- Lifetime Maximum - the greatest amount of Covered Services that a Member may receive in the Member's lifetime.

Medical Care
Services rendered by a Professional Provider for the treatment of an illness or injury. These are services that must be rendered within the scope of their license.

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

Medical Necessity Appeal
An appeal of an Adverse Benefit Determination that the request for a benefit under a health insurance policy does not meet the Health Benefit Plan's requirement for Medical Necessity,

appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/Investigative. This includes an Adverse Benefit Determination that does any of the following:

- Disapproves full or partial payment for a requested health care service;
- Approves the provision of a requested health care service for a lesser scope or duration than requested; or
- 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 Health Care Plan and did not result in the filing of a Medical Necessity Appeal (written or oral).

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; and
  - The views of Physicians practicing in relevant clinical areas; and
  - Any other relevant factors.

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.

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

Medicare Allowable Payment for Facilities
The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

Medicare Ancillary Allowable Payment
The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Service Provider.

Medicare Professional Allowable Payment
The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule - Pennsylvania Locality 01.

Member
An enrolled Employee or their Eligible Dependent(s) who have satisfied the specifications of the ***General Information*** section.

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 mental health 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.

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

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

Non-Hospital Facility
A Facility Provider, licensed by the Department of Health for the care or treatment of 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
- Free Standing Ambulatory Care Facilities.

Non-Hospital Residential Treatment
The provision of medical, nursing, counseling, or therapeutic services to Members diagnosed with Alcohol Or Drug Abuse And Dependency:
- In a residential environment;
- According to individualized treatment plans.

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.

Nutritional Formula
Liquid nutritional products which are formulated to supplement or replace normal food products.

Observation Room
Observation Room services involve the use of a bed and periodic monitoring by the Facility Provider's nursing or other ancillary staff in order to evaluate and treat a Member's condition or determine the need for possible Inpatient Admission. Observation Room services are considered Outpatient Care services and generally do not exceed 24 hours. These services can be provided in any location within a Facility Provider.

Out-of-Network Ancillary Service Provider
An Ancillary Service Provider that is NOT a member of the Personal Choice Network or is NOT a BlueCard Provider.

Out-of-Network Facility Provider
A Facility Provider that is NOT a member of the Personal Choice Network or is NOT a BlueCard Provider.

Out-of-Network Mail Order Pharmacy
A Mail Order Pharmacy that is not a member of the Health Benefit Plan's pharmacy benefits manager's network.

Out-of-Network Pharmacy
A Pharmacy that is not a member of the Health Benefit Plan's pharmacy benefits manager's network.

Out-of-Network Professional Provider
A Professional Provider who is NOT a:
- Member of the Personal Choice Network; or
- BlueCard Provider.

Out-of-Network Provider
A Facility Provider, Professional Provider, Ancillary Service Provider or Pharmacy that is NOT a:
- Member of the Personal Choice Network; or
- BlueCard Provider.

Out-of-Pocket Limit
A specified dollar amount of Covered Expense Incurred by the Member for Covered Services in a Benefit Period. The Out-of-Pocket Limits are calculated as follows:

- The In-Network Out-of-Pocket Limit expense includes Copayments, Coinsurance and Deductibles, if applicable. The amount of the In-Network Care Individual Out-of-Pocket Limit and In-Network Care Family Out-of-Pocket Limit will only include expenses for Essential Health Benefits. When the In-Network Out-of-Pocket Limit is reached, the level of benefits is increased as set forth in the ***Schedule of Covered Services***.

- The Out-of-Network Out-of-Pocket Limit expense includes Coinsurance, but does not include any Copayments, Penalties, or amounts that exceed the Health Benefit Plan's payment (see the definition for "Covered Expense" for more details). When the Out-of-Network Out-of-Pocket Limit is reached, the level of benefits is increased, as specified in the ***Schedule of Covered Services***.

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 an In-Network 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.

Partial Hospitalization
Medical, nursing, counseling or therapeutic services that are:
- Provided on a planned and regularly scheduled basis in a Hospital or Facility Provider; and
- 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.

Penalty
A type of cost-sharing in which the Member is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified and explained in detail in the ***General Information*** section.

Personal Choice Network
The network of Providers with whom the Health Benefit Plan has contractual arrangements.

Pervasive Developmental Disorders (PDD)
Disorders characterized by severe and pervasive impairment in several areas of development:
- Reciprocal social interaction skills;
- Communication skills; or
- The presence of stereotyped behavior, interests and activities.

Examples are:
- Asperger's syndrome; and
- Childhood disintegrative disorder.

Pharmacist
An individual who is legally licensed to practice the profession of Pharmacology and who regularly practices such profession in a Pharmacy.

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

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

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

Precertification (or Precertify)
Prior assessment by the Health Benefit Plan or a designated agent that proposed services, such as hospitalization, are Medically Necessary for a Member and covered by this Program. Payment for services depends on whether the Member and the category of service are covered under this Program.

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

Preferred Provider Organization (PPO)
A type of managed care plan that:
- Offers the freedom to choose a Physician like a traditional health care plan; and
- Provides the Physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization).

In a PPO, an individual is:
- Not required to select a primary care Physician to coordinate care; and
- Not required to obtain referrals to see specialists.

Prenotification (Prenotify)
The requirement that a Member provide prior notice to the Health Benefit Plan 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.

Prescription Drug
- Any medication approved by the Health Benefit Plan and which by Federal and or state laws may be dispensed with a Prescription Order; and
- Insulin.

The list of covered Prescription Drugs is subject to change from time to time at the sole discretion of the Health Benefit Plan.

Prescription Order
The request in accordance with applicable laws and regulations for medication issued by a Professional Provider.

Preventive Care
Means:
- Evidence-based items or services that are rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the Member;

- Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;
- Evidence-informed preventive care and screenings for Members who are infants, children, and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Evidence-informed preventive care and screenings for Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Any other evidence-based or evidence-informed items as determined by the federal and/or state law.

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

Primary Care Services
Basic, routine Medical Care traditionally provided to individuals with:
- Common illnesses; and
- Common injuries; and
- Chronic illnesses.

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. The Professional Providers are:
- Audiologist;
- Autism Service Provider;
- Behavior Specialist;
- Certified Midwife;
- Certified Registered Nurse;
- Chiropractor;
- Dentist;
- Independent Clinical Laboratory;
- Licensed Clinical Social Worker;
- Master's Prepared Therapist;
- Optometrist;
- Physical Therapist;
- Physician;
- Physician Assistant;
- Podiatrist;
- Psychologist;
- Registered Dietitian;
- Speech-Language Pathologist;

- Teacher of the hearing impaired.

Program
The benefit plan provided by the Group through an arrangement with the Health Benefit Plan.

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

Provider
A Facility Provider, Professional Provider, Ancillary Service Provider or Pharmacy licensed where required.

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

Psychiatric Hospital
A Facility Provider, approved by the Health Benefit Plan, 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.

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.

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 of 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.

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 Health Benefit Plan, 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 Health Benefit Plan, 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.

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.

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 with 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.

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 Provider.

Covered Services may be provided on an Outpatient or Inpatient basis.

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 Health Benefit Plan 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 Health Benefit Plan.

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 Professional 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 Professional 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 Professional 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 Health Benefit Plan to be a Self-Administered Prescription Drug or a Specialty Drug. Instead, these drugs need to be administered by a Professional Provider.

Standard Injectable Drugs include, but are not limited to:
- Allergy injections and extractions; and
- Injectable medications such as antibiotics and steroid injections that are administered by a Professional Provider.

Surgery
The performance of generally accepted operative and cutting procedures including:
- Specialized instrumentations;
- Endoscopic examinations; and
- Other invasive procedures.

Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care.

Treatment of burns, fractures and dislocations are also considered Surgery.

Therapy 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 patient'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 Professional 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 Professional 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 (a birth defect); or
  - Prior therapeutic intervention (Prior treatment).

  This does NOT include services specifically directed towards the improvement of vocational skills and social functioning.

- Physical Therapy
  Medically prescribed treatment of physical disabilities or impairments resulting from:
  - Disease;
  - Injury;

- Congenital anomaly; or
- Prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving:
  - Posture;
  - Mobility;
  - Strength;
  - 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.

- Radiation Therapy
  The treatment of disease by:
  - X-Ray;
  - Gamma ray;
  - Accelerated particles;
  - Mesons; or
  - Neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.

- Respiratory Therapy
  Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

- Speech Therapy
  Medically prescribed services that are necessary for the diagnosis and/or treatment of speech and language disorders, due to conditions or events that result in communication disabilities and/or swallowing disorders:
  - Disease;
  - Surgery;
  - Injury;
  - Congenital and developmental anomalies (birth defects); or
  - Previous therapeutic processes.

Total Disability (or Totally Disabled)
Means that a Covered Employee who, due to illness or injury:
- Cannot perform any duty of their occupation or any occupation for which the Employee is, or may be, suited by education, training and experience; and
- Is not, in fact, engaged in any occupation for wage or profit.

A Dependent is totally disabled if: They cannot engage in the normal activities of a person in good health and of like age and sex.

The Totally Disabled person must be under the regular care of a Physician.

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

Urgent Care Centers
Facility Provider designed to offer immediate evaluation and treatment for sudden health conditions and accidental injuries that:
- Require medical attention in a non-Emergency situation; and
- When the Member's Professional Provider's office is unavailable.

Urgent Care is not the same as: Emergency Services (see definition of "Urgent Care" above).

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

IMPORTANT NOTICES

Regarding Experimental/Investigative Treatment:

The Health Benefit Plan does not cover treatment it determines to be Experimental/Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Health Benefit Plan acknowledges that situations exist when a Member and their Physician agree to utilize Experimental/Investigative treatment. If a Member receives Experimental/Investigative treatment, the Member shall be responsible for the cost of the treatment. A Member or their Physician should contact the Health Benefit Plan to determine whether a treatment is considered Experimental/Investigative. The term "Experimental/Investigative" is defined in the ***Important Definitions*** section.

Regarding Treatment Which Is Not Medically Necessary:

The Health Benefit Plan only covers treatment which it determines Medically Necessary. An In-Network Provider accepts the Health Benefit Plan's decision and contractually is not permitted to bill the Member for treatment which the Health Benefit Plan determines is not Medically Necessary unless the In-Network Provider specifically advises the Member in writing, and the Member agrees in writing that such services are not covered by the Health Benefit Plan, and that the Member will be financially responsible for such services. An Out-of-Network Provider, however, is not obligated to accept the Health Benefit Plan's determination and the Member may not be reimbursed for treatment which the Health Benefit Plan determines is not Medically Necessary. The Member is responsible for these charges when treatment is received by an Out-of-Network Provider. The Member can avoid these charges simply by choosing an In-Network Provider for the Members care. The term "Medically Necessary" is defined in the ***Important Definitions*** section.

Regarding Treatment for Cosmetic Purposes:

The Health Benefit Plan does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Health Benefit Plan acknowledges that situations exist when a Member and their Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Member is responsible for the cost of the treatment. A Member or their Physician should contact the Health Benefit Plan to determine whether treatment is for cosmetic purposes. The exclusion for services and operations for cosmetic purposes is detailed in the ***Exclusions - What Is Not Covered*** section.

Regarding Coverage for Emerging Technology:

While the Health Benefit Plan does not cover treatment it determines to be Experimental/Investigative, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer’s literature. The Health Benefit Plan uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or Member, the Health Benefit Plan researches all scientific information available from these

expert sources. Following this analysis, the Health Benefit Plan makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A 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.

Regarding Use of Out-of-Network Providers

While Personal Choice has an extensive network, it may not contain every provider that the Member elects to see. To receive the Maximum benefits available under this Program, the Member must obtain Covered Services from In-Network Providers that participate in the Personal Choice Network or is a BlueCard Provider.

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

For Covered Services received from an Out-of-Network Provider, payment will be made directly to the Member and the Member will be responsible for reimbursing the Out-of-Network Provider. However, the Health Benefit Plan reserves the right, in its sole discretion, to make payments directly to the Out-of-Network Provider.

For specific terms regarding Out-of-Network Providers, please refer to the following sections: ***Important Definitions***; including but not limited to the definition of "Covered Expense" and "Out-of-Network Provider", Payment of Providers and Payment Methods.

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 Health Benefit Plan 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 Health Benefit Plan or Plan Administrator, as applicable, determines in its discretion that the Member is entitled to them.

REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of "Experimental/Investigative", "cosmetic", or "emerging technology", the Member, or their Provider, should contact the Health Benefit Plan for a coverage determination. That way the Member and the Provider will know in advance if the treatment will be covered by the Health Benefit Plan.

In the event the treatment is not covered by the Health Benefit Plan, the Member can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service.

For more information on when to contact the Health Benefit Plan for coverage determinations, please see the Precertification and Prenotification requirements in the *General Information* section.

RIGHTS AND RESPONSIBILITIES

To obtain a list of "Rights and Responsibilities", please log on to https://www.ibx.com/quality-management#member or the Member should call the Customer Service telephone number that is listed on their Identification Card to receive a printed copy.

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
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
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	Age 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 5 years
Tuberculosis testing	All children up to age 21 years

IMMUNIZATIONS (NOTE: FOR AGE 19 TO 21 YEARS, REFER TO THE ADULT SCHEDULE LISTED ABOVE)
Children Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf

Vision Benefits Program

QCC INSURANCE COMPANY
(Hereafter called "The Health Benefit Plan")

Group (Contractholder)
(Hereafter called "The Contractholder")

VISION CARE PROGRAM

QCC Insurance Company
(Hereafter called "the Health Benefit Plan")

Group Health Benefits
Benefit Booklet

The Health Benefit Plan certifies that Employees/Members in an eligible class of the Contractholder are entitled to the benefits described in this Benefit Booklet, subject to the eligibility and effective date requirements of the Group Contract.

This Benefit Booklet replaces any and all Benefit Booklets previously issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

The Contract is between the Health Benefit Plan and the Contractholder. This Benefit Booklet is a summary of the Contract provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

QCC INSURANCE COMPANY

Koleen Cavanaugh
SVP and Chief Marketing Officer

ATTEST:

Jonathan Stump
VP Product Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yorùbá: ÀKÍYÈSÍ: Tí o bá nsọ Yorùbá, àwọn iṣẹ́ àtilẹhin èdè lọ́fẹ̀ẹ́ wà lárọwọ́tó rẹ. Awọn iṣẹ́ àtilẹhìn ìrànlọ́wọ́ tó yẹ láti pèsè ìwífúnni ni ọna 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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VISION CARE COVERAGE

TABLE OF CONTENTS

SECTION 1 - SCHEDULE OF BENEFITS

VISION CARE BENEFITS

Subject to the Exclusions, conditions and Limitations of this Benefit Booklet, a Member is entitled to benefits for Covered Services described in this section during a Benefit Period, and in the amounts as specified in this ***Schedule of Benefits*** section.

Benefit Period	Once every calendar year for eye examinations, spectacle lenses or contact lenses; and once every two calendar years for frames.
Coinsurance	None
Benefit Period Maximum (Participating or Non-Participating)	$100 for all Covered Services and supplies; except eye examination services are not included in this Benefit Period Maximum.

SCHEDULE OF COVERED SERVICES

COVERED SERVICES	AMOUNTS PAYABLE AND LIMITATIONS ON COVERED SERVICES	
	Participating*	**Non-Participating**
Eye examination, inclusive of dilation, as professionally indicated.	100% of the Provider's Reasonable Charge, less a Copayment of $10 per Benefit Period.	100% of the Provider's Reasonable Charge, up to a Maximum of $40.
Eyeglasses, including Spectacle Lenses and Frames (one pair).		
Spectacle Lenses		
• All ranges of prescriptions, oversize lenses, plastic lenses, single vision, lined bifocal, lined trifocal or lenticular lenses	100%, less a Copayment of $25 per Benefit Period.	100%, up to Maximum of: $40 - single vision $60 - bifocal/progressive $80 - trifocal $100 - lenticular
• Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters	100%	Not Covered
• Scratch resistant coating	100%	Not Covered
• Ultraviolet (UV) coating	100%	Not Covered
Frames - Plan supplied: • Fashion selection • Designer selection • Premier selection	100%, with a Copayment of: $0 $15 $40	 Not Covered Not Covered Not Covered
OR - Doctor supplied:	100%, up to a Maximum of $100	100%, up to a Maximum of $50
OR - Visionworks supplied:	100%, up to a Maximum of $150	Not Covered

Elective Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses	100%, up to a Maximum of $100	100%, up to a Maximum of $80
Elective Contact Lenses Fitting and Follow-up Care	Not Covered	Not Covered
Medically Necessary Elective Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	100%	100%, up to a Maximum of $225

Out-of-pocket expenses incurred by a Member for pediatric Vision Care benefits will be included in the calculation of the Member's overall medical plan out-of-pocket limit.

* The Health Benefit Plan reserves the right to modify the ***Schedule of Covered Services*** from time to time, subject to prior notice to the Group.

SECTION 2 - VISION CARE BENEFITS

COVERED SERVICES

Subject to the Exclusions, conditions, and Limitations set forth in this Benefit Booklet, a Member is entitled to benefits of this benefit section for Covered Services rendered by a Professional Provider or Supplier, unless otherwise indicated, in the amounts specified in the section entitled ***Schedule of Benefits***.

This program allows the Member to maximize the Member's Vision Care benefits by utilizing Participating Providers. When the Member goes to a Participating Provider for an eye examination, the Member is assured of little or no out-of-pocket cost. When the Member purchases vision care hardware, such as frames and spectacle lenses or contact lenses, from a Participating Provider/Supplier, the Member may have no out-of-pocket costs, depending on the Member's choice of hardware. The program requires a Copayment amount for the purchase of some specialty hardware supplies, as shown in the ***Schedule of Benefits***. However, using Participating Providers will lower the Member's out-of-pocket costs and allow the Member to purchase most vision care hardware at fixed, reduced prices. The Member will receive a listing of the Professional Providers that participate in the QCC Insurance Company's Vision Care Program.

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

- The Non-Participating Provider is not a Participating Provider.
- The Member has the option of selecting a Participating Provider.
- The Member may have different financial obligations depending on whether the Vision Care Provider is Participating or Non-Participating.

Vision Care services received from a Non-Participating Provider are not covered under this Health Benefit Plan.

The Program also provides benefits if the Member chooses to use Non-Participating Providers and Suppliers. Benefits are payable up to the Benefit Period Maximum amounts shown in the ***Schedule of Benefits*** for eye examinations and vision care hardware provided by Non-Participating Providers.

The Benefit Period Maximum amount shown in the ***Schedule of Benefits*** is applicable to either all Participating Covered Services or all Non-Participating Covered Services per Benefit Period.

Professional Services

- Eye Examination Services
  Such services, performed by a Professional Provider, as defined in the section entitled ***Important Definitions*** shall include, but are not limited to:
  - Case history.
  - Visual acuity, near and far.
  - External examination, including biomicroscopy or other magnified evaluation of the anterior chamber.
  - Objective, subjective and ophthalmoscopic examinations.
  - Binocular measure.
  - Summary, findings, and recommendations.
- Hardware
  - Contact Lens Prescription and Fitting Services
    Such services, performed by a Professional Provider shall include, but are not necessarily limited to:
    - Keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve.
    - Proper fitting of appropriate contact lenses, including the training of insertion and removal of trial contact lenses to the Member's corneas.
    - Post-dispensing contact lens follow-up care, including correction of any ill-fitting or unsuitable lenses.

    Contact Lens Prescription and Fitting Services must be preceded by Eye Examination Services as described in the "Eye Examination Services" subsection shown above.
  - Post-Refractive Services
    Post-refractive Services consist of the ordering of lenses and frames (facial measurements, lenticular formula and other specifications), cost of the materials, verification of the completed prescription upon return from the laboratory, adjustment of the completed eyeglasses to the Member's face and the subsequent servicing (For Example, refitting, realigning, readjusting, tightening).

Limitations

- In cases involving Covered Services in which the Professional Provider or Supplier and Member elect to utilize photogrey or light sensitive lenses, the program may provide benefits providing the Member qualifies for such benefits. See the ***Schedule of Benefits*** for the benefit allowance, if any.
- Payment for frames, or spectacle lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.

SECTION 3 - EXCLUSIONS - WHAT IS NOT COVERED

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

- For examinations or materials which are not listed herein as a Covered Service;
- For any lenses which do not require a prescription;
- For an eye examination without a refraction;
- For replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the Member would otherwise meet the frequency limitations. However, this does not apply to plan-supplied frames and spectacle lenses obtained from a Participating Provider if breakage occurs during normal use within 365 days of the dispensing date;
- For the cost of any insurance premiums indemnifying the Member against losses for lenses or frames;
- For sunglasses, regardless of whether they are prescribed, VDT eyeglasses and safety goggles;
- For medical attention or surgical treatment of the eye;
- For diagnostic services, such as diagnosis X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;
- For drugs or any other medications;
- For procedures, such as but not limited to, orthoptics, vision therapy, subnormal vision aids, and tonography;
- For eye examinations or materials sponsored by the Member's employer without charge to the Member;
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Member claims the benefits or compensation, unless the Member is an owner or executive officer and claims an exemption permitted by law;
- For which a Member would have no legal obligation to pay;
- Received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- Incurred prior to the Member's Effective Date;
- Incurred after the date of termination of the Member's coverage except for lenses and frames prescribed prior to such termination and delivered within 30 days from such date;

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

- For duplicate and temporary devices, appliances, and services. This exclusion does not apply to disposable contact lenses;

- For which the Member incurs no charge;

- In a facility performed by a Professional Provider or Supplier who in any case is compensated by the facility for similar Covered Services performed for Members;

- Treatment or services 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;

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

- Paid or payable by Medicare when Medicare is primary. For purposes of this Program, a service, supply or charge is "payable under Medicare" when the Member is eligible to enroll for Medicare benefits, regardless of whether the Member actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

- For low vision aids;

- For eyeglass frames and contact lenses dispensed within the same Benefit Period by a Participating Provider;

- Other than specifically provided in the section entitled ***Vision Care Benefits*** of this Benefit Booklet.

SECTION 4 - WHO IS COVERED

Eligible Person

- Eligible Person is defined as a Member who is determined by the Contract Holder as eligible to apply for coverage and sign the Application; and
- Eligible Dependents as specified to the Health Benefit Plan by the Contract Holder as eligible for coverage.

Eligible Dependent

Eligible Dependent is defined as:

- The Member's spouse under a legally valid existing marriage between persons of the opposite sex.
- The unmarried children, including newborn children, step-children, children legally placed for adoption, and legally adopted children of the Member or the Member's spouse, or children for whom the Member is a legal guardian or newborns of dependent children covered under the Group Contract. The limiting age for covered, unmarried children is to the first of the month following the month in which they reach age 26; or if a student is enrolled full-time in an Accredited Educational Institution, the limiting age 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 the Accredited Educational Institution. The Health Benefit Plan must receive certification from the full-time student's physician that the full-time student is suffering from a serious illness or injury that requires a Medically Necessary leave of absence from the Accredited Educational Institution or requires the full-time student to become a part-time student. 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 Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):
  - Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
  - Notifying the Health Benefit Plan 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 the Dependent's 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 retardation or physical handicap, mental illness or developmental disability and who are dependent for support upon a Member covered under the Group Contract. The Health Benefit Plan may require proof of such Member's eligibility from time to time.

- The newborn child(ren) of a Member from the moment of birth to a maximum of 31 days immediately following birth. The coverage of newborn children within such 31 day period shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities and prematurity and services of a doctor rendered as part of nursery care, but not nursery charges. To continue coverage beyond the 31 day period, application for coverage must be made within 31 days of the child's birth and the appropriate premium paid.
- 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.

Effective Date
The date the Contract Holder agrees that all Eligible Persons may apply and become covered. If a person becomes an Eligible Person after the Contract Holder's Effective Date, that date becomes the Effective Date.

SECTION 5 - GENERAL INFORMATION

Benefits To Which Members Are Entitled

- The liability of the Health Benefit Plan is limited to the benefits specified in the Group Contract.
- No person other than a Member is entitled to receive benefits under this Program.
- Benefits for Covered Services will be provided only for services and supplies that are rendered by a Professional 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 Health Benefit Plan before the Health Benefit Plan 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 Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Contract Holder notified the Health Benefit Plan of such termination.

Continuation Of Coverage At Termination Of Employment Or Membership Due To Total Disability

A Member's benefits under this Program may be extended after the date that person ceases to be a Member under the Group Contract because of termination of employment or termination of membership in the group. It will be extended if, on that date, the person is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the person remains Totally Disabled from any such illness or injury, but not beyond 12 months if the person ceases to be a Member because the Group Contract ends.

The Health Benefit Plan will provide benefits under the Group Contract during an extension as if the person were still a Member. In addition, the Health Benefit Plan will provide benefits only to the extent that other coverage for the Covered Services is not provided for the by the Contract Holder. Continuation of coverage is subject to payment of the applicable premium.

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.

When The Employee Terminates Employment - Continuation Of Coverage Provisions 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.

For purposes of this subsection, a "qualified beneficiary" means any person who, before any event which would qualify that person 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:

- A covered Employee;
- The Employee's spouse; or
- The Employee's Dependent child.

In addition, any child born to or placed for adoption with the Employee 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 Employee during Mini-COBRA continuation, will not be a qualified beneficiary.

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

  The continuation will cover the Employee and any other qualified beneficiary who loses coverage because of the Employee'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 Employer's Responsibilities: The Employee's employer must notify the Employee, the plan administrator, and the Health Benefit Plan, in writing, of:
  - The Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours;

- The Employee's death;
- The Employee's divorce or legal separation from an eligible dependent;
- The Employee becomes eligible for benefits under Social Security;
- The Employee's dependent child ceases to be a dependent child pursuant to the terms of the group health benefits Benefit Booklet;
- Commencement of Employer's bankruptcy proceedings.

The notice must be given to the Employee, the plan administrator and the Health Benefit Plan 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 administrator or its designee of their election of continuation coverage within 30 days of receipt of the Notice from the Employer.

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

Upon receipt of the Employee's, or the Employee's eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

- If an Employee Dies: If the covered Employee 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 an Employee's Marriage Ends: If the Employee'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 Employee's Dependent child's group health benefits end due to the Dependent's loss of dependent eligibility as defined in this Benefit Booklet, other than the Employee's coverage ending, the Dependent 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 Continuation Ends" paragraph of this subsection.

- Election of Continuation: To continue the qualified beneficiary's group health benefits, the qualified beneficiary must give the plan administrator written notice that the qualified beneficiary elects to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of the qualified beneficiary's continuation rights from the plan administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Health Benefit Plan 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 plan administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the plan 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 benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to 5% of the total premium charge may also be required by the Health Benefit Plan.

- 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 ends on the first to occur of the following:
  - With respect to continuation upon the Employee'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 Employee's death, the Employee's legal divorce or legal separation, or the end of the Employee'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 Employee's Dependent whose continuation is extended due to the Employee'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 the qualified beneficiary becomes 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 the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
  - The date the Employee and/or eligible dependent become eligible for Medicare.

THE HEALTH BENEFIT PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS PROGRAM ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BENEFIT BOOKLET.

THE HEALTH BENEFIT PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE PROGRAM OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

Continuation Of Incapacitated Child

If the Member's 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 Health Benefit Plan to continue coverage of such child under this Program upon such terms and conditions as the Health Benefit Plan 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 19.

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 Health Benefit Plan for the first time, the handicapped child must have been covered under the prior Health Benefit Plan and submit proof from the prior Health Benefit Plan that the child was covered as a handicapped person.

Timely Filing
The Health Benefit Plan will not be liable under this Program unless proper notice is furnished to the Health Benefit Plan that Covered Services have been rendered to a Member. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Health Benefit Plan to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

The Member's failure to give notice to the Health Benefit Plan within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Health Benefit Plan be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

Release Of Information
Each Member agrees that any person or entity having information relating to any Services or Supplies for which benefits are claimed under this Program may furnish to the Health Benefit Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, the Health Benefit Plan may furnish similar information to other entities providing similar benefits at their request. The Health Benefit Plan shall provide to the Contract Holder, at the Contract Holder's request, any and all information regarding claims and charges submitted to the Health Benefit Plan by Professional Providers. The parties understand that any information provided to the Contract Holder will be adjusted by the Health Benefit Plan to prevent the disclosure of the identity of any Member or other patient treated by said Professional Providers. The Contract Holder shall reimburse the Health Benefit Plan for the actual costs of preparing and providing said information. The Health Benefit Plan shall provide the Contract Holder with such cost figure and obtain the Contract Holder's approval of such expense prior to incurring such costs.

The Health Benefit Plan may also furnish membership and/or coverage information for the purpose of claims processing or facilitating patient care.

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

Claim Forms
The Health Benefit Plan will furnish to the Member making the claim, or to the Contract Holder, for delivery to such Member, such forms as are required for filing proof of loss.

Time Of Payment Of Claims
All benefits payable under this Program will be payable not more than 60 days after receipt of proof.

Right To Recover Payments In Error
If the Health Benefit Plan should pay for any contractually excluded services through inadvertence or error, the Health Benefit Plan maintains the right to seek recovery of such payment from the Professional Provider, Supplier or Member to whom such payment was made.

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 two years after the date services are rendered.

Member/Provider Relationship
- The choice of a provider is solely the Member's.
  - The Health Benefit Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Health Benefit Plan is not liable for any act or omission of any Professional Provider or Supplier. The Health Benefit Plan has no responsibility for a Professional Provider's or Supplier's failure or refusal to render Covered Services to a Member.

Agency Relationships
The Contract Holder is the agent of the Member, not the Health Benefit Plan.

Identification Cards And Benefit Booklets
The Health Benefit Plan will provide the Identification Cards to Members or to the Contract Holder, depending on the direction of the Contract Holder. The Health Benefit Plan will also provide to each Member of an enrolled group a Benefit Booklet describing the benefits provided under the Group Contract.

Member Rights
A Member shall have no rights or privileges as to the benefits provided under this Program except as specifically provided herein.

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 Contract Holder, or sent to the Member's last address furnished to the Health Benefit Plan by the Contract Holder. The Contract Holder, the Health Benefit Plan, 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 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 Allowable Charges, 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 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.

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 (For Example, use of Participating Providers), or to the administration of this Program by the Health Benefit Plan, the Health Benefit Plan 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 Health Benefit Plan 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 Health Benefit Plan nor the Participating 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 Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot;
- Civil insurrection; or
- Public health emergency.

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.

SECTION 6 - RESOLVING PROBLEMS

(APPEAL OF AN ADMINISTRATIVE DENIAL AND MEDICAL NECESSITY APPEAL PROCESS)

Informal Member Complaint Process
The Health Benefit Plan has a process for Members to request an informal Complaint. To register an informal Complaint, Members should call the Member Services Department at the telephone number on the back of their Identification Card or write to the Health Benefit Plan at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this stage. If the Health Benefit Plan cannot immediately resolve the Member's concern, the Health Benefit Plan will acknowledge it in writing within **five business days** of receiving the request. The Member will receive a response within 30 calendar days. If the Member is not satisfied with the response to their concern from the Health Benefit Plan, the Member has the right to file a formal appeal through the Member's Appeal of an Administrative Denial process described below.

Authorizing Someone to Represent the Member
At any time, the Member may choose a third party to be their representative in their Member appeal such as a provider, lawyer, relative, friend, another individual, or a person who is part of an organization. The law states that the Member's written authorization or consent is required in order for this third party called an "authorized representative" to pursue an appeal on the Member's behalf. An authorized representative may make all decisions regarding the Member's appeal, provide and obtain correspondence, and authorize the release of medical records and any other information related to their appeal. In addition, if the Member chooses to authorize an appeal representative, the Member has the right to limit their authority to release and receive the Member's medical records or other appeal information in any other way the Member identifies.

To authorize someone to be the Member's authorized representative, the Member must complete valid authorization forms. The required forms are sent to adult Members or to the parents, guardians, or other legal representatives of minor or incompetent Members who appeal and indicate that they want an authorized representative to appeal on their behalf. Authorized representative forms can be obtained by calling or writing to the address listed below:

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

Except in the case of an expedited appeal, the Health Benefit Plan must receive completed, valid authorization forms before the Member's appeal can be processed. (For information on expedited appeals, see the definition below and the references in the Appeal of an Administrative Denial Process and the Medical Necessity Appeal Process sections below.) The

Member has the right to withdraw or rescind authorization of an authorized representative at any time during the process.

If the Member's provider files an appeal on the Member's behalf, the Health Benefit Plan will verify that the provider is acting as the Member's authorized representative with their permission by obtaining valid authorization forms. A Member who authorizes the filing of an appeal by a provider cannot file a separate appeal.

Information for the Appeal Review:

How to File and Get Assistance
Appeals may be submitted by the Member or their authorized representative with the Member's authorization by following the steps outlined below in the descriptions of the Appeal of an Administrative Denial and the Medical Necessity Appeal Process. At any time during these appeal processes, the Member may request the help of a Health Benefit Plan employee in preparing or presenting their appeal; this assistance will be available at no charge. Please note that the Health Benefit Plan employee designated to assist the Member will not have participated in the previous decision to deny coverage for the issue in dispute and will not be a subordinate of the original reviewer.

Full and Fair Review
The Member or authorized representative is entitled to a full and fair review. Specifically, at all appeal levels the Member or authorized representative may submit additional written comments, records or other information pertaining to the case, to the Health Benefit Plan. The Health Benefit Plan takes into account all information submitted by the Member, whether such information was submitted or considered during the initial Adverse Benefit Determination or prior level of review. The Health Benefit Plan documents when the Member fails to submit relevant information by the specified deadline. The Member or authorized representative may specify the remedy or corrective action being sought. At the Member’s or authorized representative’s request, the Health Benefit Plan will provide access to and copies of all relevant documents, records, and other information (excluding the Health Benefit Plan’s confidential, proprietary, or privileged information). The Health Benefit Plan will automatically provide the Member or authorized representative with any new or additional evidence considered, relied upon, or generated by the Health Benefit Plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as possible and in advance of the date the adverse notification is issued. This information is provided to the Member or authorized representative at no charge.

Advance Notice
The Health Benefit Plan will not terminate or reduce an-ongoing course of treatment without providing the Member or authorized representative with advance notice and the opportunity for advanced review.

Urgent Care
In the appeal context, urgent care is medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. Members with urgent care conditions or who are receiving an on-going course of treatment may request an internal expedited appeal and also proceed with an expedited external review at the same time.

Changes in Member Appeals Processes
Please note that the Member appeals processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Member appeals processes, or to reflect other decisions regarding the administration of Member appeals processes for this Program.

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

Appeal Classifications
Appeals of an Administrative Denial and Medical Necessity Appeals, established by Pennsylvania state laws and regulations, are described in detail in separate sections below.

An Appeal of an Administrative Denial may be filed to challenge a denial based on a contract limitation, prior authorization, coverage or payment based on a lack of eligibility, failure to submit complete information or other failure to comply with an administrative policy, certain surprise medical bills received by a Member from an out-of-network provider, rescissions of coverage (except for failure to pay premiums or coverage contributions) or to complain about other aspects of health plan policies or operations that has not been resolved by the Health Benefit Plan and has been filed with the Pennsylvania Insurance Department (PID).

A Medical Necessity Appeal may be filed when the denial of a covered service is based primarily on Medical Necessity, experimental/investigative exclusions, or cosmetic exclusions.

You may question the classification of your appeal as an Appeal of an Administrative Denial or Medical Necessity Appeal by contacting the Health Benefit Plan's Member Appeals Department or your assigned appeals specialist at the address and telephone number shown above or by contacting the Pennsylvania Insurance Department at:

Pennsylvania Insurance Department
Bureau of Health Care Access,
Administration, and Appeals (HCA3)
1311 Strawberry Square
Harrisburg, PA. 17120
Toll Free: 1-888-466-2787
Fax: 1-717-787-8555
E-Mail:RA-lNHCA3@pa.gov.

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

Appeals are also subject to the following classifications:

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

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

Internal Standard Appeal of an Administrative Denial
The Member or authorized representative may file an Appeal of an Administrative Denial for an unresolved dispute or objection. The Appeal of an Administrative Denial process consists of two internal levels of review by the Health Benefit Plan, and one external level of review by the Pennsylvania Insurance Department.

Internal Standard First Level Appeal of an Administrative Denial-
The Member or authorized representative may file an internal standard first level Appeal of an Administrative Denial **within 180 calendar days** from either their receipt of the original notice or the completion of the **Informal Member Complaint Process** described above. To file an internal standard first level Appeal of an Administrative Denial, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

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

The Member or authorized representative may submit an oral or written appeal. Additionally, The Member or authorized representative may submit written data or other information to the Health Benefit Plan for consideration regarding the appeal. The Health Benefit Plan will acknowledge receipt of the Member's Appeal of an Administrative Denial in writing.

The internal standard first level Appeal of an Administrative Denial is decided by a Health

Benefit Plan employee who has no previous involvement with the case and who is not the subordinate of anyone previously involved with the case. The decision notification is sent to the Member or authorized representative within:

- **15 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal.

If the Member's appeal is denied, the decision letter states:

- The specific reason for the decision;
- This Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to appeal to the next level if the Member is not satisfied with the decision.

Internal Standard Second Level Appeal of an Administrative Denial

If the Member or authorized representative is not satisfied with the decision from their first level Appeal of an Administrative Denial, they may file an internal standard second level appeal to the Second Level Appeal of an Administrative Denial Committee **within 60 calendar days** of their receipt of the First Level Committee's decision from the Health Benefit Plan. To file a second level appeal, call Customer Service toll free at the telephone number listed on the Member's ID card, or call, write or fax the Member Appeals Department as follows:

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

Upon receipt of the Member's appeal, the Member or authorized representative will be notified in writing in advance of a date and time scheduled for the Internal Standard Second Level Appeal of an Administrative Denial Committee meeting. The Member or authorized representative may request a change in the meeting schedule. The Health Benefit Plan will do its best to accommodate their request while remaining within the established timeframes. If the Member or authorized representative does not participate in the meeting, the Second Level Committee will review their Appeal of an Administration Denial and make its decision based on all available information.

The Second Level Appeal of an Administrative Denial Committee meets and renders a decision on the Member's standard appeal and notifies the Member or authorized representative within:

- **15 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal.

The Internal Standard Second Level Appeal of an Administrative Denial Committee is composed of at least three persons who have had no previous involvement with the Member's case and who are not subordinates of the person who made the original determination. The Second Level Appeal of an Administrative Denial Committee members will include the Health Benefit Plan's staff, with one third of the Committee being other persons who are not employed by the Health Benefit Plan. The Member or authorized representative may submit supporting materials both before and at the appeal meeting. Additionally, the Member or authorized representative has the right to review all information considered by the Committee that is not the Health Benefit Plan's confidential, or privileged information.

The Internal Standard Second Level Appeal of an Administrative Denial Committee meeting is a forum where Members have an opportunity to present their issues via a video conference or conference call in an informal setting that is not open to the public. Members of the press may only participate in their personal capacity as the Member's authorized representative or to provide general, personal assistance. Members, authorized representatives, and others assisting the Member may not audiotape or videotape the Committee proceedings.

The Member/authorized representative will be sent the decision letter of the Internal Standard Second Level Appeal of an Administrative Denial Committee on their appeal **within five business days** of the date the decision is made. The notice will include the basis for the denial and the procedure for appealing the decision to the Pennsylvania Insurance Department's Bureau of Health Care Access, Administration and Appeals (HCA3) or the Bureau of Consumer Affairs. The Member may be represented by an attorney or other individual in the state review. The decision is final unless the Member chooses to appeal to the Pennsylvania Insurance Department as described in the decision letter. (See also **External Appeal of an Administrative Denial** below.)

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

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

The Member's request for external review of an Appeal of an Administrative Denial should include the Member's name, address, daytime telephone number, the name of the Health Benefit Plan as their health care plan, the group number, the Member's Health Benefit Plan ID number and a brief description of the issue being appealed. Also include a copy of the Member's original request for an internal second level standard appeal review to the Health Benefit Plan and copies of any correspondence and decision letters from the Health Benefit Plan.

When an external Appeal of an Administrative Denial request is submitted to the Pennsylvania Insurance Department‘s HCA3 or Bureau of Consumer Services, the original submission date of the request is considered the date of receipt. The regulatory agency that receives the request will review it and transfer it to the other agency if this is found to be appropriate. The regulatory agency that handles the Member's external appeal will provide the Member and the Health Benefit Plan with a copy of the final determination of its decision.

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

Internal Standard Medical Necessity Appeal Process

Member Appeal Process for Decisions Based on Medical Necessity
Members/authorized representatives may file a formal Medical Necessity Appeal of a decision by the Health Benefit Plan regarding a Covered Drug that was denied or limited based primarily on Medical Necessity, the cosmetic or experimental/investigative exclusions, or other grounds that rely on a medical or clinical judgment (including appropriateness, health care setting and level of care or effectiveness).

The appeal process consists of one internal review by the Health Benefit Plan and if appealed further, an external review conducted by an accredited private Independent Review Organization (IRO). The external review is coordinated by the Pennsylvania Insurance Department’s HCA3. There is also an internal and external expedited Medical Necessity Appeal process in the event the Member's condition involves an urgent issue.

The Member or authorized representative may file an internal standard Medical Necessity Appeal **within 180 calendar days** from the date of receipt of the original denial by the Health Benefit Plan. To do so, call Customer Service at the toll-free telephone number listed on their ID Card, or call, write or fax the Member Appeals Department as follows:

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

The Health Benefit Plan will acknowledge receipt of the Member's Medical Necessity Appeal in writing. This confirmation advises that the Health Benefit Plan considers the matter to be a Medical Necessity Appeal and that the Member or authorized representative may question the classification by contacting the HCA3. or the Bureau of Consumer Services at the information listed above.

The Member's one level of internal appeal is reviewed by a Health Benefit Plan Medical

Director, who is the decision-maker. This individual holds an active unrestricted license to practice medicine, has had no previous involvement in the case, and is not a subordinate of the person who made the original determination. Additionally, the Health Benefit Plan Medical Director is a same or similar specialist, or the decision-maker receives input from an independent consultant who is a same or similar specialist. A same or similar specialist or "same or similar specialty Physician" is a licensed Physician or psychologist who is in the same or similar specialty as typically manages the case under review. Additionally, the physician consultant:

- Has had no previous involvement in the case;
- Is not a subordinate of the person who makes the original determination;
- Is not a subordinate of anyone previously involved with the case.

If the same or similar specialist Physician is a consultant, their opinion on the Medical Necessity Appeal issues will be reported to the Health Benefit Plan in writing for consideration. The Member or authorized representative may request a copy of the same or similar specialist's opinion in writing, and it will be provided to the Member or authorized representative prior to the date of review by the Health Benefit Plan Medical Director. The same or similar specialist's report includes their credentials as a licensed Physician or psychologist such as board certification.

The Health Benefit Plan Medical Director completes the review of the Member's standard appeal and sends notification to the Member or authorized representative within:

- **30 calendar days** from receipt of a pre-service appeal; and
- **30 calendar days** from receipt of a post-service appeal;
- **72 hours** from receipt of a standard non-formulary exception appeal request.

The Member or authorized representative will be sent the decision on their internal appeal in writing **within five business days** of the determination. If the Member's Medical Necessity Appeal is denied, the decision letter states:

- The specific reason for the denial;
- The Health Benefit Plan's provision on which the decision is made and instructions on how to access the provision; and,
- How to request an external review if the Member is not satisfied with the decision.

Internal Expedited Medical Necessity Appeals

If the Member's case involves an urgent care condition, then the Member or their Physician (or authorized representative) may ask to have the Member's case reviewed in a faster manner, as an Expedited Medical Necessity Appeal. The Health Benefit Plan also grants an expedited Medical Necessity Appeal review for all requests concerning admissions, continued stay or other health care services for a Member who has received Emergency services but has not been discharged from a facility. There is one internal level of appeal review for an Expedited Medical Necessity appeal.

Members with Urgent Care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

To request an Internal Expedited Medical Necessity Appeal review by the Health Benefit Plan, call Customer Service at the toll-free telephone number listed on the Member's ID card, or call, or fax the Member Appeals Department at the telephone numbers listed above. The Health Benefit Plan will promptly inform the Member whether their appeal request qualifies for

expedited review or instead will be processed as a standard Medical Necessity Appeal.

The decision process for an Internal Expedited Medical Necessity Appeal mirrors the one described above for the Internal Standard Medical Necessity Appeal.

The Internal Expedited Medical Necessity Appeal review is completed promptly based on the Member's health condition. The Health Benefit Plan conducts an expedited internal review and issues a decision to the Member, authorized representative, and practitioner/provider **within 72 hours** of the date the Health Benefit Plan receives the appeal. For non-formulary exception requests, the appeal is decided, and notification sent **within 24 hours** of receipt of the request. The notification includes the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

EXTERNAL REVIEW INDEPENDENT REVIEW ORGANIZATION (IRO) PROCESS

External Appeal Process For Decisions Based On Medical Necessity, Experimental/Investigative Treatment, Cosmetic Issues, Certain Surprise Medical Bills Received by Members From Out-of-Network Providers, and Recissions of Coverage (except for non-payment of premiums or coverage contributions).

The Member or authorized representative may file a written request for an external appeal with the HCA3 **within four months** of the receipt of the Health Benefit Plan's Adverse Benefit Determination or final Adverse Benefit Determination for an internal Medical Necessity Appeal. The HCA3 contracts directly with the IRO and notifies the Health Benefit Plan of the assignment for each case file. The HCA3 is also responsible for keeping IRO pricing at a reasonable level. The Member or authorized representative does not pay any of the cost for an external review.

Please refer to the final internal appeal Adverse Benefit Determination letter for specific instructions on how to file the appeal with the HCA3.

A Member/authorized representative may only request an external review after exhausting the Health Benefit Plan's internal appeal process. The Member/authorized representative shall be deemed to have exhausted the Health Benefit Plan's internal appeal process in the following circumstances:

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

Preliminary Review of an External Review Request

The HCA3 will send a copy of the external review request to the Health Benefit Plan **within one business day** of receipt of the request. **Within five business days** of the Health Benefit Plan's receipt of this copy, the Health Benefit Plan will perform a preliminary review to determine whether:

- The individual is or was a Member under the health insurance policy at the time the health care service was requested, or in the case of a retrospective utilization review, at the time the health care service was provided.
- The health care service that is the subject of the external review request is covered under the Member's health insurance policy, except for determinations by the Health Benefit Plan that a health care service is not covered because it does not meet the Health Benefit Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.
- The Member has exhausted the Health Benefit Plan's internal Medical Necessity Appeal process.
- The Member has not provided all required information and forms to process an external review.

For an external review of denial of coverage of an experimental/investigative treatment, the Health Benefit Plan's preliminary review will also include a determination of whether:

- The health care service is covered under the Member's health insurance policy, except for the Health Benefit Plan's determination that the health care service is experimental/investigative for a particular condition.
- The health care service is not explicitly listed as an excluded benefit under the Member's health insurance policy.
- The Member's treating health care provider has certified that one of the following situations is applicable:
  - Standard health care services have not been effective in improving the condition of the Member.
  - Standard health care services are not medically appropriate for the Member.
- There are no available standard health care services under the health insurance policy that are more beneficial than the recommended or requested health care services described in the next paragraph.
- The Member's treating health care provider either:
  - Has recommended health care services that the health care provider certifies, in writing, are more likely to be beneficial to the Member, in the health care provider's opinion, than available standard health care services.
  - Has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care services requested by the Member who is the subject of the Adverse Benefit Determination or final Adverse Benefit Determination, are likely to be more beneficial to the Member than any available standard health care services, when the treating health care provider is a licensed, board-certified or board-eligible Physician qualified to practice in the area of medicine appropriate to treat the Member's condition.

External Review Process

Within one business day of completion of the preliminary review, the Health Benefit Plan notifies the HCA3, the Member/authorized representative in writing whether the request is complete and eligible for external review.

- If the request is not complete, the Health Benefit Plan notifies the Member/authorized representative and HCA3 in writing, including what information or materials are needed to make the request complete.
- If the request is not eligible for an external review, the Health Benefit Plan informs the Member/authorized representative and the HCA3 in writing, including the reason(s) why the request is not eligible.
  - The Member/authorized representative may appeal the Health Benefit Plan's initial determination that the external review request is ineligible for review to the HCA3.
  - Despite the Health Benefit Plan's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the Health Benefit Plan and the Member and may be appealed to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

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

The HCA3 sends written notification to the Member/authorized representative of the eligibility of the request based on the preliminary review and of the name and contact information of the assigned IRO. Additionally, the HCA3 notifies the Member/authorized representative they may send the IRO additional information **within 15 business days** of receipt of the HCA3's notification. **Within one business day** of receiving additional information from the Member/authorized representative, the IRO sends a copy of the information to the Health Benefit Plan.

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

Reconsideration by the Health Benefit Plan

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

An external review may be terminated without an IRO determination if the Health Benefit Plan overturns their decision that is the subject of the external review and provides coverage or payment for the recommended health care service that is the subject of the external review. **Within one business day** of deciding to overturn their decision, the Health Benefit Plan will notify the HCA3, IRO, and the Member/authorized representative in writing of its decision. The assigned IRO will terminate the external review upon receipt of this notice.

Standard External Review IRO Decision

The assigned IRO decides the appeal and sends notification to the Member/authorized representative **within 45 calendar days** of receipt of the external review request. For an external review of experimental/investigative treatment, the assigned IRO makes a decision and sends notification to the Member/authorized representative **within 20 calendar days** of receipt of the external review of the experimental/investigative treatment request. For non-formulary exception requests, the IRO makes a decision and sends notification **within 72 hours** of receipt of the request.

Upon receipt of an IRO overturn decision, the Health Benefit Plan will approve the request that was the subject of the external review **within 24 hours**.

Expedited External Review

The Member or authorized representative may make an oral or written request to the HCA3 for an expedited external review. A retrospective case is not eligible for an expedited external review.

Please refer to the final internal appeal Adverse Benefit Determination letter for specific instructions on how to file the appeal with the HCA3.

A Member/authorized representative may request an expedited external review in the following circumstances:

- The Member has an urgent care condition for which the time for a standard external review decision would seriously jeopardize the life, or health of the Member or jeopardize their ability to regain maximum function.
- The final Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which a Member receives emergency care but has not been discharged from a facility.

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

- The Member has an urgent care condition for which the timeframe for completion of an expedited internal review of the Adverse Benefit Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function.
- The final Adverse Benefit Determination involves a determination that the recommended or requested health care service is experimental/investigative, and the Member's treating health care provider certifies in writing that the recommended or requested health care service that is the subject of the Adverse Benefit Determination would be significantly less effective if not promptly initiated.

Preliminary Review of an Expedited External Review Request
Upon receipt of an expedited external review, the HCA3 sends a copy of the request to the Health Benefit Plan **within 24 hours**.

- **Within 24 hours** of receipt of the request from the HCA3, the Health Benefit Plan determines if the request meets the requirements for an external review and notifies the HCA3 and Member/authorized representative of the Health Benefit Plan's eligibility determination.
  - The Member/authorized representative may appeal the Health Benefit Plan's initial determination that the external review request is ineligible for review to the HCA3.
  - Despite the Health Benefit Plan's initial determination, the HCA3 may determine, based upon the terms of the Member's health insurance policy, that a request is eligible for external review. This determination will be binding on the Health Benefit Plan. The Member/authorized representative may appeal to the PID Commissioner. Consideration of this appeal may not delay or terminate the external review.

Expedited External Review Process
Upon receipt of the Health Benefit Plan's notification that the request meets the eligibility requirements, the HCA3 assigns an IRO to conduct the expedited external review **within 24 hours**.

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

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

Expedited External Review IRO Decision
Within 72 hours of receipt of the request, the IRO makes their decision and notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan. For non-formulary exception requests, the IRO makes their decision **within 24 hours** of the request and notifies the Member/authorized representative, the HCA3, and the Health Benefit Plan.

Upon receipt of an IRO overturn decision, the Health Benefit Plan will approve the request that was the subject of the expedited external review **within 24 hours**.

Binding Decision for External Reviews
An IRO decision is binding on the Health Benefit Plan except to the extent the Health Benefit Plan has other remedies available under applicable state law. An IRO decision is binding on the Member/authorized representative, except to the extent the Member/authorized representative has other remedies available under applicable Federal and state laws.

Neither the Member or the authorized representative may file a subsequent request for an external review involving an Adverse Benefit Determination or final Adverse Benefit Determination for which the Member has already received a decision for the same Adverse Benefit Determination or final Adverse Benefit Determination.

If the Member's Health Benefit Plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following the Member's appeal, the Member may have the right to bring civil action under Section 502(a) of the Act. For questions about the Member's rights, or for assistance, the Member can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) (TTY: 711) . Additionally, a consumer assistance program may be able to assist the Member at:

Pennsylvania Insurance Department
1325 Strawberry Square
Harrisburg, PA 17111
1-877-881-6388 (TTY: 711)
www.insurance.pa.gov

SECTION 7 - IMPORTANT DEFINITIONS

For the purposes of this Benefit Booklet, the terms below have the following meaning:

Accredited Educational Institution
A publicly or privately operated academic institution of higher learning which:
- Provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and
- Is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

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

Adverse Benefit Determination
A determination that includes any denial, reduction, or rescission of health insurance coverage (when, in connection with the rescission, there is an adverse effect on a particular benefit at that time). An Adverse Benefit Determination may be any of the following:
- A determination by the Health Benefit 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 Health Benefit Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental/investigative, 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 Health Benefit 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 Health Benefit Plan.

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 Health Benefit 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 Health Benefit Plan and did not result in the filing of an Appeal of an Administrative Denial (written or oral).

Benefit Period
The specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by the Health Benefit Plan. A charge shall be considered Incurred on the date the service or supply was provided to a Member.

Billed Charge
An amount billed by a Supplier or Professional Provider for treatment, services or supplies rendered to a Member.

Coinsurance
A specific percentage of the Provider's Reasonable Charge for Covered Services set forth in the section entitled ***Schedule of Benefits*** of this Benefit Booklet, for which the Member is responsible.

- Program Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to all Covered Services for which the Member is responsible.
- Benefit Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to a specific Covered Service for which the Member is responsible.

Complaint
Any expression of dissatisfaction, verbal or written, by a Member.

Contract
The Group Policy of Vision Care Benefits, including the Group Application, riders and/or endorsements, if any, between the Health Benefit Plan and the Contractholder, also referred to as the Group Contract.

Contractholder
Any individual, corporation or other entity who, as the representative of an enrolled group of Employees (Members) and as Agent for the Members is acceptable to the Health Benefit Plan. The Contractholder has agreed to pay the charges payable under the Contract to the Health Benefit Plan and to receive any information from the Health Benefit Plan on behalf of the Applicants.

Copayment
A specified amount of expenses applied to a specific Covered Service for which the Member is responsible per Covered Service.

Covered Service
A service or supply specified in this Benefit Booklet for which benefits will be provided when rendered by a Professional Provider or Supplier. For purposes of this Program, the term "Covered Services and Supplies" means Covered Services, with the exception of Eye Examination Services.

Dependent
A Member other than the Employee as specified in the section entitled ***Who Is Covered***.

Domestic Partner (Domestic Partnership)
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 Health Benefit Plan reserves the right to request documentation of any of the foregoing prior to commencing coverage for the Domestic Partner.

Effective Date
A date on which coverage for a Member begins under the Group Contract.

Employee
An individual in the Contract Holder who meets the eligibility requirements for enrollment and who is so specified for enrollment.

Eye Examination Services
A comprehensive examination and evaluation of the eyes performed by a physician, Ophthalmologist or Optometrist, which shall include, but not be limited to, the services listed in the "Eye Examination Services" subsection of the section entitled ***Vision Care Benefits***.

Family Coverage
Coverage for the Employee and one or more of the Employee's Dependents.

Incurred
A charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

Lens
A transparent refracting medium, usually made of plastic.
- Aphakic - a lens prescribed for those who have had the crystalline lens of the eye removed during cataract surgery or who were born without a crystalline lens.
- Bifocal - a lens containing two different powers, one for distance vision, and one for near vision.
- Disposable Contact - a soft plastic contact lens that is applied to the eye for correcting refractive errors for a period of approximately one to two weeks and is then discarded.
- Hard Contact - a curved glass or plastic lens that is applied to the eye for correction of refractive errors.
- Lenticular - a type of aphakic lens prescribed to replicate the crystalline lens of the eye.
- Single Vision - a lens with one correction, for either distance or near vision.
- Soft Contact - a lens for correcting refractive errors. They are of soft plastic material.
- Trifocal - a lens that has three distinct areas for visual focus.

Limitations
The Maximum frequency as set forth in the section entitled ***Schedule of Benefits***, for which a Covered Service is allowed.

Maximum
The greatest amount payable by the Health Benefit Plan set forth in the ***Schedule of Benefits***, for Covered Services. This could be expressed in dollars or a specified number of services for a specified period of time.

- Program Maximum - the greatest amount payable by the Health Benefit Plan for Covered Services.
- Benefit Maximum - the greatest amount payable by the Health Benefit Plan for a specific Covered Service.

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 Health Benefit Plan's requirement for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental/investigative. This includes an Adverse Benefit Determination that does any of the following:

- Disapproves full or partial payment for a requested health care service;
- Approves the provision of a requested health care service for a lesser scope or duration than requested; or
- 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 Health Care Plan and did not result in the filing of a Medical Necessity Appeal (written or oral).

Member
An enrolled Employee and their Eligible Dependents who have satisfied the specifications under the section entitled ***Who Is Covered*** of this Benefit Booklet.

Non-Participating Provider
A Professional Provider that does not participate in the Health Benefit Plan's programs and is not required to accept the Health Benefit Plan's payment as payment-in-full.

Ophthalmologist
Is a Physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform Eye Examination and Refractive Services.

Optician
Is a person who makes, fits, supplies and adjusts eyeglasses in accordance with a prescription written by a Professional Provider to correct a Member's optical defects. Opticians are not Professional Providers.

Optometrist
Is a person licensed to practice optometry in accordance with the provisions of the Optometric Practice and Licensure Act, and whom may perform Eye Examination and Refractive Services.

Participating Provider
A Professional Provider that has an agreement with the Health Benefit Plan pertaining to payment for Covered Services rendered to a Member.

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.

Professional Provider
A person or practitioner licensed where required and performing within the scope of such licensure. The Professional Providers include:
- Doctor of Medicine
- Doctor of Ophthalmology
- Doctor of Optometry
- Doctor of Osteopathy
- Physician

Provider's Reasonable Charge
The dollar amount on which a Member's Coinsurance, Benefit Maximums and benefits will be calculated. "Provider's Reasonable Charge" shall mean the following:
- For services rendered by a Participating Provider, "Provider's Reasonable Charge" means the rate of reimbursement for Covered Services determined by contract, or the Billed Charge, whichever is less; or
- For services rendered by a Non-Participating Provider, "Provider's Reasonable Charge" means the Reasonable and Customary Charges, or Benefit Maximums amount, or Billed Charge, whichever is less.

Reasonable And Customary
Means the amount that is the usual or customary charge for the service or supply as determined by the Health Benefit Plan. The chosen standard is an amount which is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, the Health Benefit Plan determines what is reasonable by the severity and/or complexity of the Member's condition for which the service or supply is provided.

Supplier
A provider engaged in dispensing ophthalmic material (For example, contact lenses, spectacle lenses) in accordance with a prescription written by a Professional Provider. Supplies include, but are not limited to, Opticians and retail optical dispensing firms.

Total Disability
Except as otherwise specified in this Benefit Booklet, a Member who, due to illness or injury, cannot perform any duty of their occupation or any occupation for which they are, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if they cannot engage in the normal activities of a person in good health and of like age and sex. The Member or Dependent person must be under the regular care of a Physician.

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.

[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)

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

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

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

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

COVERAGE

Persons Covered

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

Amounts of Coverage

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

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

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

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

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

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

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

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

NOTICES

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

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

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

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

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