



Villanova University
800 Lancaster Ave
Villanova, PA 19085

August 18, 2023

Re: Your QCC Insurance Company Benefit Program

Dear Administrator:

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

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

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

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

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

Sincerely,

A handwritten signature in black ink that reads "Kileen A. Cavanaugh".

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

Enc.

Agreed to and Accepted:

Name: Michela Mocarisky

Date: 10/18/2023

THE PERSONAL CHOICE HEALTH BENEFITS PROGRAM
A COMPREHENSIVE MAJOR MEDICAL GROUP BENEFIT BOOKLET

Administered by

QCC Insurance Company
(Called "the Claims Administrator")
A Pennsylvania Corporation
Located at
1901 Market Street
Philadelphia, PA 19103

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Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilfgriech in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian:

សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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 differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these 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. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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INTRODUCTION

Thank you for joining QCC Insurance Company (the Claims Administrator). 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 Claims Administrator 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 Program Document available through the Member's Group benefits administrator. The information in this Benefit Booklet is subject to the provisions of the Group Program Document. If changes are made to the Members Group's Program, the Member will be notified by the Members Group benefits administrator. Group Program Document 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 Program Document 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 Claims Administrator's procedures and services. **If Members have any other questions, they should call the Claims Administrator'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 Program Document 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 Program Document 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		
Individual	\$300	\$1,500
Family	\$900*	\$4,500*
<p>* In each Benefit Period, it will be applied to all family members covered under a Family Coverage. A Deductible will not be applied to any covered family member once that covered family member has satisfied the individual Deductible, or that covered family member has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.</p>		
	IN-NETWORK	OUT-OF-NETWORK
Coinsurance	10% for Covered Services, except as otherwise specified in the <i>Schedule of Covered Services.</i>	30% for Covered Services, except as otherwise specified in the <i>Schedule of Covered Services.</i>
Out-of-Pocket Limit		
Individual	\$3,000	\$6,000
Family	\$9,000	\$18,000
<p><i>Note for Out-Of-Pocket Limit shown above:</i> When a Member Incurs the level of In-Network Out-of-Pocket expenses listed above of Copayment, 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 that Benefit Period. After the Family In-Network Out-of-Pocket Limit amount has been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Copayment(s) or Deductible(s) will be required for the balance of that 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 amounts specified shall not include any expense Incurred for any Penalty amount. When a Member Incurs the level of Out-of-Network Out-of-Pocket expenses listed above of Deductible and Coinsurance expense in one Benefit Period for Out-of-Network Covered Services, the Coinsurance percentage will be reduced to 0% and no additional Deductible(s) will be required for the balance of that Benefit Period. After the Family Out-of-Network Out-of-Pocket Limit amount has been met for Covered Services by Members under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% and no additional Deductible(s) will be required for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Network Out-of-Pocket amount. The Out-of-Network dollar amounts specified shall not include any expense Incurred for any Deductible, Penalty or Copayment amount.</p>		
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⁾	\$50 Copayment per visit, Deductible does not apply	30%, after Deductible
<i>Note for Acupuncture shown above: Benefit Period Maximum: 18 In-Network/Out-of-Network visits</i>		
Alcohol Or Drug Abuse And Dependency⁽³⁾		
Inpatient Hospital Detoxification and Rehabilitation	10%, after Deductible*	30%, after Deductible**
Hospital and Non-Hospital Residential Care	10%, after Deductible*	30%, after Deductible**
Outpatient Treatment		
Office Visit	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
All Other	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Telebehavioral Health	\$30 Copayment per visit, Deductible does not apply	30%, 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.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Ambulance Services/Transport ⁽⁴⁾		
Emergency	None, Deductible does not apply	None, Deductible does not apply
Non-Emergency	10%, after Deductible	30%, after Deductible
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.)
<p><i>Note for Autism Spectrum Disorders shown above:</i></p> <p>There is no Annual Benefit Maximum for Essential Health Benefits The Annual Benefit Maximum for non-essential health benefits is: \$45,808. Benefit Period Maximums and visit limits do not apply</p> <p>If this Program does not provide coverage for prescription drugs, Autism Spectrum Disorders medications are covered less the applicable Coinsurance per 30 day prescription order: Generic Coinsurance – 30% Brand Coinsurance – 30% Deductible does not apply</p>		
Blood ⁽³⁾	10%, after Deductible	30%, after Deductible
Colorectal Cancer Screening ⁽⁴⁾	10%, after Deductible	30%, after Deductible
Day Rehabilitation Program ⁽⁴⁾	10%, after Deductible	30%, after Deductible
<p><i>Note for Day Rehabilitation Program shown above:</i> Benefit Period Maximum: 30 In-Network/Out-of-Network visits</p>		
Diabetic Education Program ⁽⁴⁾	10%, after Deductible	Not Covered
<p><i>Note for Diabetic Education Program shown above:</i> Copayments, Deductibles and Maximum amounts do not apply to this benefit</p>		
Diabetic Equipment And Supplies ⁽⁴⁾	30%, after Deductible	50%, after Deductible
Durable Medical Equipment And Consumable Medical Supplies ⁽⁴⁾	30%, after Deductible	50%, after Deductible
Emergency Care Services ⁽⁴⁾	\$100 Copayment per visit (waived if admitted), Deductible does not apply	\$100 Copayment per visit (waived if admitted), Deductible does not apply
Home Health Care ⁽⁴⁾	10%, after Deductible	30%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Hospice Services⁽³⁾	10%, after Deductible	30%, after Deductible
<i>Note for Hospice Services shown above: Respite Care: Maximum of seven In-Network/Out-of-Network days every six months.</i>		
Hospital Services⁽²⁾		
Facility Charge	10%, after Deductible*	30%, after Deductible**
Professional Charge	None, Deductible does not apply	30%, after Deductible
<p>* 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.</p> <p>** 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.</p>		
Immunizations⁽¹⁾	None, Deductible does not apply	30%, Deductible does not apply
Injectable Medications⁽⁴⁾		
Specialty Drug	\$50 Copayment per injection, after Deductible	30%, after Deductible
Standard Injectable Drugs	None, after Deductible	30%, after Deductible
Insulin and Oral Agents⁽⁴⁾	None, less the Copayment amount, if applicable	None, less the Copayment amount, if applicable
<p><i>Note for Insulin and Oral Agents shown above: If this Program does not provide coverage for prescription drugs, insulin and oral agents are covered less the applicable Copayment per prescription order</i></p> <p style="text-align: center;">Generic Copayment - \$10 Brand Copayment - \$15</p>		
Laboratory and Pathology Tests⁽⁴⁾	None, Deductible does not apply	30%, after Deductible
Maternity/OB-GYN/Family Services⁽³⁾		
Artificial Insemination	10%, after Deductible	30%, after Deductible
Assisted Reproductive Technology Lifetime Maximum Benefit: \$30,000	10%, after Deductible	30%, after Deductible
Elective Abortions		
Professional Service	None, Deductible does not apply	30%, after Deductible
Outpatient Facility Charges	10%, after Deductible	30%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Professional Service	Single Copayment of \$30, Deductible does not apply	30%, after Deductible
Facility Service: Inpatient/Birthing Center	10%, after Deductible	30%, after Deductible
Newborn Care	10%, after Deductible	30%, after deductible
<i>Note for Newborn Care shown above: Cost-sharing does not apply for the first 31 days following birth</i>		
Medical Care ⁽²⁾	10%, after Deductible	30%, after Deductible
Medical Foods and Nutritional Formulas ⁽⁴⁾	10%, after Deductible	30%, Deductible does not apply
Mental Health/Psychiatric Care ⁽³⁾		
Inpatient	10%, after Deductible*	30%, after Deductible**
Outpatient		
Office Visit	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
All Other	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Telebehavioral Health	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
<p>* 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.</p> <p>** 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.</p>		
Methadone Treatment ⁽⁴⁾	None, Deductible does not apply	30%, after Deductible
Nutrition Counseling For Weight Management ⁽¹⁾	None, Deductible does not apply	30%, after Deductible
<i>Note for Nutrition Counseling For Weight Management shown above: Benefit Period Maximum: 6 In-Network/Out-of-Network visits</i>		
Orthotics ⁽⁴⁾	30%, after Deductible	50%, after Deductible
Podiatric Care ⁽⁴⁾	\$50 Copayment per visit Deductible does not apply	30%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Preventive Care – Adult⁽¹⁾	None, Deductible does not apply	30%, Deductible does not apply
Routine/Preventive Colonoscopy		
Preventive Plus (P+) Facility/Non-Hospital based Facility*	None, Deductible does not apply	Not Covered
Non-Preventive Plus (P+) Facility/Hospital based Facility	None**, Deductible does not apply	30%, Deductible does not apply
<p>* For \$0 (None) Member cost-sharing to apply, all services must be performed by an In-Network gastroenterologist or a colon and rectal surgeon.</p> <p>** The Copayment will be waived if the In-Network Provider determines that it is Medically Necessary to have the service performed by a Provider that is Hospital based.</p> <p><i>Note for Routine/Preventive Colonoscopy shown above:</i> There is no cost-share applied if the preventive colonoscopy service is performed at a facility that is not Hospital based (For example, an Ambulatory Surgical Facility); if the preventive colonoscopy service is performed at a Hospital based facility, the Hospital based Copayment shown above will apply. In addition to seeking services from Preventive Plus (P+) Providers, colonoscopy screenings must meet the United State Preventive Services Task Force's (USPSTF) guidelines for \$0 (None) Member cost-sharing to apply.</p>		
Preventive Care – Pediatric⁽¹⁾	None, Deductible does not apply	30%, Deductible does not apply
Primary Care Physician Office Visits/Retail Clinics⁽¹⁾	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
<p><i>Note for Primary Care Physician Office Visits/Retail Clinics/Telemedicine Visits shown above:</i> If a Member receives Covered Services in addition to an office visit, additional Copayments, Deductibles or Coinsurance may apply.</p>		
Private Duty Nursing Services⁽⁴⁾	10%, after Deductible	30%, after Deductible
<p><i>Note for Private Duty Nursing Services shown above:</i> Benefit Period Maximum: 360 In-Network/Out-of-Network hours.</p>		
Prosthetic Devices⁽⁴⁾	30%, after Deductible	50%, after Deductible
Radiology Services – Non-Routine⁽⁴⁾ (including MRI/MRA, CT scans, PET scans)		
Providers that are not Hospital based	\$50 Copayment per visit, Deductible does not apply	30%, after Deductible
Providers that are Hospital based	\$50 Copayment per visit, Deductible does not apply	30%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Radiology Services – Routine⁽⁴⁾		
Providers that are not Hospital based	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Providers that are Hospital based	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Diagnostic Mammograms	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Skilled Nursing Facility Services⁽²⁾	10%, after Deductible	30%, after Deductible
<i>Note for Skilled Nursing Facility Services shown above: Benefit Period Maximum: 120 In-Network/Out-of-Network Inpatient days</i>		
Sleep Studies⁽⁴⁾		
Home/Freestanding Sleep Center	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Facility Charge	\$30 Copayment per visit, Deductible does not apply	30%, after Deductible
Smoking Cessation⁽¹⁾	None, Deductible does not apply	30%, Deductible does not apply
Specialist Office Visits⁽⁴⁾	\$50 Copayment per visit, Deductible does not apply	30%, after Deductible
Spinal Manipulation Services⁽⁴⁾	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
<i>Note for Spinal Manipulation Services shown above: Benefit Period Maximum: 20 In-Network/Out-of-Network visits.</i>		
Surgical Services⁽³⁾		
Outpatient Facility Charge	10%, after Deductible	30%, after Deductible
Outpatient Professional Charge	10%, after Deductible	30%, after Deductible
Outpatient Anesthesia	10%, after Deductible	30%, after Deductible
Second Surgical Opinion	\$50 Copayment per opinion, Deductible does not apply	30%, after Deductible
<i>Note for Surgical Services shown above: If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Claims Administrator will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.</i>		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Therapy Services⁽⁴⁾		
Cardiac Rehabilitation Therapy	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
<i>Note for Cardiac Rehabilitation Therapy shown above</i> Benefit Period Maximum: 36 In-Network/Out-of-Network sessions.		
Chemotherapy	None, Deductible does not apply	30%, after Deductible
Dialysis	None, Deductible does not apply	30%, after Deductible
Infusion Therapy		
Home/Office	10%, after Deductible	30%, after Deductible
Outpatient	10%, after Deductible	30%, after Deductible
Orthoptic/Pleoptic Therapy	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
<i>Note for Orthoptic/Pleoptic Therapy shown above:</i> Lifetime Maximum: 8 In-Network/Out-of-Network sessions.		
Physical Therapy/Occupational Therapy		
Providers that are not Hospital based	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
Providers that are Hospital based	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
<i>Note for Physical Therapy/Occupational Therapy shown above:</i> 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.		
Pulmonary Rehabilitation Therapy	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
<i>Note for Pulmonary Rehabilitation Therapy shown above:</i> Benefit Period Maximum: 36 In-Network/Out-of-Network sessions.		
Radiation Therapy	None, Deductible does not apply	30%, after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Therapy Services⁽⁴⁾ (continued)		
Speech Therapy	\$50 Copayment per Provider per date of service, Deductible does not apply	30%, after Deductible
<i>Note for Speech Therapy shown above: Benefit Period Maximum: 20 In-Network/Out-of-Network sessions.</i>		
Transplant Services⁽³⁾		
Inpatient Facility Charge	10%, after Deductible	30%, after Deductible
Outpatient Facility Charge	10%, after Deductible	30%, after Deductible
Urgent Care Centers⁽⁴⁾	\$50 Copayment per visit, Deductible does not apply	30%, after Deductible
Women's Preventive Care⁽¹⁾	None, Deductible does not apply	30%, Deductible does not apply
<i>Note for Women's Preventive Care shown above: Contraceptives mandated by the Women's Preventive Services provision of PPACA, are covered at 100% for certain generic products and brand products. All other contraceptive products are not covered.</i>		

BENEFIT	If the Member utilizes a contracted vendor	If the Member does not utilize a contracted vendor
Virtual Care Services⁽⁴⁾		
Telemedicine Visit (Vendor/Virtual Provider)	\$10 Copayment per visit, Deductible does not apply	Not Covered
Teledermatology	\$10 Copayment per visit, Deductible does not apply	Not Covered
Telebehavioral Health	\$10 Copayment per visit, Deductible does not apply	Not Covered

(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 Claims Administrator 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 Claims Administrator reviews the schedule of Covered Services, at certain times. Reviews are based on recommendations from organizations such as:

- The American Academy of Pediatrics;
- The American College of Physicians;
- The U.S. Preventive Services Task Force; and
- The American Cancer Society.

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

The Claims Administrator reserves the right to modify the Preventive Schedule document at any time. However, the Member has to be given a written notice of the change, before the change takes effect.

Immunizations

The Claims Administrator will provide coverage for the following:

- Pediatric immunizations;
- Adult immunizations; and
- The agents used for the immunizations.

All immunizations, and the agents 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 for Weight Management

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

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

Preventive Care - Adult

The Claims Administrator 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 Claims Administrator 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

The Claims Administrator 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.

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 Claims Administrator 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 Claims Administrator 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, not including abortifacient drugs, 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.

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 Claims Administrator.

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 Claims Administrator will provide coverage for all ancillary services usually provided and billed for by Hospitals, except for personal convenience items. This includes, but is not limited to:

- Meals, including special meals or dietary services, as required by the Member's condition;
- Use of operating room, delivery room, recovery room, or other specialty service rooms and any equipment or supplies in those rooms;
- Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
- Oxygen and oxygen therapy;
- Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
- Therapy Services when administered by a person who is appropriately licensed and authorized to perform such services;
- All drugs and medications (including intravenous injections and solutions);
 - For use while in the Hospital;
 - Which are released for general use; and
 - Which are commercially available to Hospitals.
- Use of special care units, including, but not limited to intensive care units or coronary care units; and
- Pre-admission testing.

■ **Room and Board**

The Claims Administrator will provide coverage for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

- An average semi-private room, as designated by the Hospital; or a private room, when designated by the Claims Administrator as semi-private for the purposes of this Program in Hospitals having primarily private rooms;
- A private room, when Medically Necessary;
- A special care unit, such as intensive or coronary care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
- A bed in a general ward; and
- Nursery facilities.

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

It is Medical Care that is rendered:

- By a 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 Claims Administrator will provide coverage for the following services, while the Member is an Inpatient, when they occur together:

- Services rendered to the Member by a 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 Claims Administrator 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 Claims Administrator will provide coverage for a Skilled Nursing Facility:

- When Medically Necessary as determined by the Claims Administrator.
- 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator will provide coverage for the administration of blood and blood processing from donors. In addition, benefits are also provided for:

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

Hospice Services

The Claims Administrator will provide coverage for palliative and supportive services 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 Claims Administrator will provide coverage for the Member to receive the same kind of care in the following way:
 - On a short-term basis;
 - As an Inpatient; and
 - In a Medicare certified Skilled Nursing Facility.This can only be arranged when the Hospice considers such care necessary to relieve primary caregivers in the Member's home.

Maternity/OB-GYN/Family Services

■ Assisted Reproductive Technology

The Claims Administrator 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 Claims Administrator 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 Claims Administrator will provide coverage for Covered Services rendered in the care and management of a pregnancy for a Member.

- Pre-notification - The Claims Administrator should be notified of the need for maternity care within one month of the first prenatal visit to the Physician or midwife.
- Facility and Professional Services - The Claims Administrator 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 Claims Administrator 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 Claims Administrator.

- 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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;
- Tele-Behavioral 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 Claims Administrator provides coverage for Routine Patient Costs Associated with Participation in a Qualifying Clinical Trial (see the **Important Definitions** section).
- To ensure coverage and appropriate claims processing, the Claims Administrator must be notified in advance of the Member's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by 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 Claims Administrator 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 Claims Administrator.

Surgical Services

The Claims Administrator 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 Claims Administrator will provide coverage for the following when performed after a mastectomy:
 - All stages of reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prosthesis 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.
- Anesthesia
 - The Claims Administrator 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 Claims Administrator to be Medically Necessary and when a successful result cannot be expected for treatment under local Anesthesia, or when a superior result can be expected from treatment under general Anesthesia.
- Assistant at Surgery

The Claims Administrator will provide coverage for an assistant surgeon's services if:

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

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 Claims Administrator will provide coverage for a Hospital admission in connection with dental procedures or Surgery only when:

- The Member has an existing non-dental physical disorder or condition; and
- Hospitalization is Medically Necessary to ensure the Member's health.

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

■ Oral Surgery

The Claims Administrator will provide coverage for 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 Claims Administrator reserves the right to seek recovery from the Provider.

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

■ Second Surgical Opinion (Voluntary)

The Claims Administrator will provide coverage for consultations for Surgery to determine the Medical Necessity of an elective surgical procedure.

- "Elective Surgery" is that Surgery which is not of an Emergency or life threatening nature;
- Such Covered Services must be performed and billed by a 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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.

■ Inpatient Treatment

- 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.

■ Outpatient Treatment

- 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 Claims Administrator will provide coverage for Acupuncture up to the limits specified in the **Schedule of Covered Services** for all Covered Services.

Ambulance Services/Transport

The Claims Administrator will provide coverage for ambulance services. However, these services need to be:

- Medically Necessary as determined by the Claims Administrator; and
- Used for transportation in a specially designed and equipped vehicle that is used only to transport the sick or injured and only when 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 Claims Administrator 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 Claims Administrator.

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 Claims Administrator (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 Claims Administrator, when:
 - The transfer is Medically Necessary (as determined by the Claims Administrator's definition of Medical Necessity); and
 - The Member's medical condition requires uninterrupted care and attendance by qualified medical staff during transport by ground ambulance, or by air transport when transfer cannot be safely provided by land ambulance.

Non-Emergency ambulance transports are not provided for family members or companions or for the convenience of the Member, the family, or the Provider treating the Member.

Autism Spectrum Disorders (ASD)

The Claims Administrator will provide coverage for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Members under 21 years of age subject to the Annual Benefit Maximum specified in the **Schedule of Covered Services**.

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician assistant, licensed Psychologist or Certified Registered Nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than 12 months, unless a licensed Physician or licensed Psychologist determines an earlier assessment is necessary.

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 Claims Administrator once every six months. A more or less frequent review can be agreed upon by the Claims Administrator and the licensed Physician or licensed Psychologist developing the ASD Treatment Plan.

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. If this Program does not provide coverage for prescription drugs, ASD medications may be purchased at a pharmacy, and the Member will be reimbursed at 100% less the applicable Coinsurance amount shown in the **Schedule of Covered Services**. Benefits are available for up to a 30 day supply.
- 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 Claims Administrator 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 Claims Administrator will provide coverage for colorectal cancer screening for Symptomatic Members, Nonsymptomatic Members over age 50, and Nonsymptomatic Members under age 50 who are at high risk or increased risk for colorectal cancer. Coverage for colorectal cancer screening must be in accordance with the current American Cancer Society guidelines, and consistent with approved medical standards and practices. 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 Claims Administrator will provide coverage for the purchase of Consumable Medical Supplies when:

- It is used in the Member's home; and
- It is obtained through a Professional Provider.

Day Rehabilitation Program

The Claims Administrator will provide coverage for a Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

- Intensity of need for therapy: The Member must require intensive Therapy services, such as Physical, Occupational and/or speech Therapy 5 days per week for 4 to 7 hours per day;
- Ability to communicate: The Member must have the ability to communicate (verbally or non-verbally); their needs; they must also have the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff;
- Willingness to participate: The Member must be willing to participate in a Day Rehabilitation Program; and
- Family support: The Member's family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

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

Diabetic Education Program

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

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

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 Claims Administrator.

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

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

Diabetic Equipment and Supplies

- Coverage and costs: The Claims Administrator will provide coverage for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. This is subject to any applicable Deductible, Copayment and/or Coinsurance requirements applicable to Durable Medical Equipment benefits.
- When diabetic equipment and supplies can be purchased at a pharmacy: If this Program provides benefits for prescription drugs (other than coverage for insulin and oral agents only):
 - Certain Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, if available;
 - This will be subject to the cost-sharing arrangements, applicable to the prescription drug coverage.
- When diabetic equipment and supplies are not available at a pharmacy:
 - The diabetic equipment and supplies will be provided under the Durable Medical Equipment benefit;
 - This will be subject to the cost-sharing arrangements applicable to Durable Medical Equipment.
- Covered Diabetic Equipment:
 - Blood glucose monitors;
 - Insulin pumps;
 - Insulin infusion devices; and
 - Orthotics and podiatric appliances for the prevention of complications associated with diabetes.
- Covered Diabetic Supplies:
 - Blood testing strips;
 - Visual reading and urine test strips;
 - Insulin and insulin analogs*;
 - Injection aids;
 - Insulin syringes;
 - Lancets and lancet devices;
 - Monitor supplies;
 - Pharmacological agents for controlling blood sugar levels*; and
 - Glucagon emergency kits.

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

Diagnostic Services

The Claims Administrator will provide coverage for the following Diagnostic Services, when ordered by a 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 Claims Administrator; 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 Claims Administrator, these services are covered for the purpose of:

- Diagnosis;
- Screening;
- Predicting the course of a disease;
- Judging the response to a therapy;
- Examining risk for a disease; or
- Reproductive decision-making.

Durable Medical Equipment

The Claims Administrator will provide coverage for the rental or, at the option of the Claims Administrator, 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 Claims Administrator.

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 Claims Administrator will provide coverage for the repair or replacement of Durable Medical Equipment

when the equipment does not function properly; and is no longer useful for its intended purpose, in the following limited situations:

- Due to a change in a Member's condition: When a change in the Member's condition requires a change in the Durable Medical Equipment the Claims Administrator will provide repair or replacement of the equipment;
- Due to breakage: When the Durable Medical Equipment is broken due to significant damage, defect, or wear, the Claims Administrator will provide repair or replacement only if the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Claims Administrator.

Breakage under warranty: If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contacts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of:

- The Claims Administrator in the case of rented equipment; and
- The Member in the case of purchased equipment.

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

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

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

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 Claims Administrator. They are provided at the In-Network level of benefits, regardless of whether the Member is treated by a 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 Claims Administrator.

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

Home Health Care

- Covered Services: The Claims Administrator will provide coverage for the following services when performed by a licensed Home Health Care Provider:
 - Professional services of appropriately licensed and certified individuals;
 - Intermittent skilled nursing care;
 - Physical Therapy;
 - Speech Therapy;
 - Well mother/well baby care following release from an Inpatient maternity stay; and
 - Care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy.
- Regarding well mother/well baby care: With respect to well mother/well baby care following early release from an Inpatient maternity stay, Home Health Care services must be provided within 48 hours if:
 - Discharge occurs earlier than 48 hours of a vaginal delivery; or
 - Discharge occurs earlier than 96 hours of a cesarean delivery.No cost-sharing shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.
- Regarding other medical services and supplies: The Claims Administrator 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 Claims Administrator.
- Regarding Medical Necessity: Home Health Care benefits will be provided only when prescribed by the Member's attending Physician, in a written Plan Of Treatment and approved by the Claims Administrator as Medically Necessary.
- Regarding the issue of being confined: There is no requirement that the Member be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.
- Regarding being Homebound: With the exception of Home Health Care provided to a Member, immediately following an Inpatient release for maternity care, the Member must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

Injectable Medications

The Claims Administrator will provide coverage for injectable medications required in the treatment of an injury or illness when administered by a 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 Claims Administrator. 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>.

- Copayments and Coinsurance apply:
 - The purchase of all Specialty Drugs is subject to:
 - ❖ A Copayment, if dispensed by an In-Network Provider; or
 - ❖ Coinsurance, if dispensed by an Out-of-Network Provider.
 - The Copayment and Coinsurance amounts are shown in the **Schedule of Covered Services**.
- Copayment and 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; in such a case, the Member will be subject to three Copayments, if applicable.

- Dual Coverage
- Coverage and costs: The Claims Administrator will provide coverage for an injectable medication in accordance with Medical Policy coverage criteria and the terms and conditions of this Benefit Booklet. This is subject to any applicable Deductible, Copayment and/or Coinsurance or 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 Claims Administrator to be a Self-Administered Prescription Drug or a Specialty Drug.
- Standard Injectable Drugs include, but are not limited to:
 - Allergy injections and extractions; and
 - Injectable medications such as antibiotics and steroid injections that are administered by a 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 and the description of "Insulin and Oral Agents" coverage in the **Description of Covered Services** section.

Insulin and Oral Agents

The Claims Administrator will provide coverage for Insulin and oral agents to control blood sugar as prescribed by a Physician and dispensed by a licensed pharmacy. Benefits are available for up to a 30 day supply when dispensed from a retail pharmacy.

Medical Foods and Nutritional Formulas

- The Claims Administrator will provide coverage for Medical Foods when provided for the therapeutic treatment of inherited errors of metabolism (IEMs) such as:
 - Phenylketonuria;
 - Branched-chain ketonuria;
 - Galactosemia; and
 - Homocystinuria.

Coverage is provided when administered on an Outpatient basis, either orally or through a tube.

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

The Claims Administrator 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 IEMs, or for when administered through a tube.

Non-Surgical Dental Services

The Claims Administrator will provide coverage only for:

- The initial treatment of Accidental Injury/trauma, (That is, fractured facial bones and fractured jaws), in order to restore proper function.

Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound Natural Teeth, required for the initial treatment for the Accidental Injury/trauma. This includes:

- The first caps;
- Crowns;
- Bridges; and
- Dentures (but not dental implants).

- The preparation of the jaws and gums required for initial replacement of Sound Natural Teeth. 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.

Orthotics (Devices Used for Support of Bones and Joints)

The Claims Administrator will provide coverage for:

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

Podiatric Care

The Claims Administrator 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.

Private Duty Nursing Services

The Claims Administrator will provide coverage up to the number of hours as specified in the **Schedule of Covered Services** for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician and which are Medically Necessary as determined by the Claims Administrator.

Prosthetic Devices

The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Visits

The Claims Administrator 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.

Spinal Manipulation Services

The Claims Administrator will provide coverage for the detection and correction of structural imbalance or dislocation (subluxation) of the Member's spine resulting from, or related to any of the following:

- Distortion of, or in, the vertebral column;
- Misalignment of, or in, the vertebral column; or
- Dislocation (Subluxation) of, or in, the vertebral column.

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

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

Therapy Services

The Claims Administrator will provide coverage, 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 Claims Administrator'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 Claims Administrator.

■ 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.

■ Orthoptic/Pleoptic Therapy

Includes treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye Surgery, or injury resulting in the lack of vision depth perception.

■ Physical Therapy

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

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

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

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

Virtual Care Services

- Services Provided by a contacted vendor

Virtual care services are provided by contracted vendors who are licensed to provide standard medical assessments, treatments, care and services to patients via the telephone, secure video, audio or instant messaging 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 Claims Administrator in the Claims Administrator'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 Claims Administrator'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:

Abortion Services

For abortion services, other than abortion services performed to avert the death of the mother on certification of a Physician, in the case of a pregnancy caused by rape, or in the case of a pregnancy caused by incest.

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.

Autism

- For Autism Spectrum Disorders services that exceed the Annual Benefit Maximum shown in the **Schedule of Covered Services**.
- 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.

Contraception

For Contraceptives.

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.

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*.

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 Claims Administrator, 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 Claims Administrator, 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 Claims Administrator.

Home Blood Pressure Machines

For home blood pressure machines, except for Members:

- With pregnancy-induced hypertension;
- With hypertension complicated by pregnancy;
- With end-stage renal disease receiving home dialysis; or
- Who are eligible for home blood pressure machine benefits as required based on ACA preventive mandates.

Home Health Care

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

- Custodial services, food, housing, homemaker services, Home delivered meals and supplementary dietary assistance;
- Rental or purchase of Durable Medical Equipment;
- Rental or purchase of medical appliances (For example, braces) and Prosthetic Devices (For example, artificial limbs); supportive environmental materials and equipment, such as:
 - Handrails;
 - Ramps;
 - Telephones;
 - Air conditioners and similar services;
 - Appliances; and
 - Devices.

- Prescription drugs;
- Provided by family members, relatives, and friends;
- A Member's transportation, including services provided by voluntary ambulance associations for which the Member is not obligated to pay;
- Emergency or non-Emergency Ambulance services;
- Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- Services provided to individuals (other than a Member released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
- Visits by any Provider personnel solely for the purpose of assessing a Member's condition and determining whether or not the Member requires and qualifies for Home Health Care services and will or will not be provided services by the Provider.

Hospice Care

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 Claims Administrator:
 - 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 Claims Administrator 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;
 - Camp; 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 Weight Management".
- 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, but not limited to:

- Weight management programs;
- Dietary aids, supplements, injections and medications;
- Weight training, fitness training, or lifestyle modification programs, including such programs provided under the supervision of a clinician; and
- Group nutrition counseling.

This exclusion does not apply to:

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

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

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

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; | ■ Elevators; |
| ■ Humidifiers; | ■ Sauna; |
| ■ Physical fitness or exercise equipment; | ■ Television; |
| ■ Radio; | ■ Spa or health club memberships; |
| ■ Beauty/barber shop services; | ■ Whirlpool; |
| ■ Guest trays; | ■ Telephone; |
| ■ Wigs; | ■ Guest Service; or |
| ■ Chairlifts; | ■ Hot tub or equivalent device. |
| ■ Stairglides; | |

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

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

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 Services**.

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 Claims Administrator.

Reversal of a Sterilization

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

Routine Foot Care

As defined in the Claims Administrator'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 Claims Administrator; 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.

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 Claims Administrator approved by the Department of Military & Veterans Affairs (DMVA):

- Notifying the Claims Administrator that the Dependent has been placed on active duty;
- Notifying the Claims Administrator that the Dependent is no longer on active duty; 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.

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 Claims Administrator may require proof of eligibility under the prior Claims Administrator'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 Claims Administrator 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 Claims Administrator.

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 Claims Administrator is limited to the benefits specified in this Benefit Booklet. The Claims Administrator'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 Claims Administrator before the Claims Administrator receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Claims Administrator will consider the effective date of termination of a Member under this Program to be not more than 60 days before the first day of the month in which the Group notified the Claims Administrator 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 Claims Administrator does not furnish Covered Services but only makes payment for Covered Services received by persons covered under this Program. The Claims Administrator is not liable for any

act or omission of any Provider. The Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered 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 Program Document 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 Claims Administrator, 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 **Complaint and 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 60 days after the date of termination of this Program. Once the Member receives notice and the Member elects a conversion plan, payment for coverage under the conversion contract must be made within 31 days. 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 Claims Administrator 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 Claims Administrator to continue coverage of such child under this Program upon such terms and conditions as the Claims Administrator may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 26.

The 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 Claims Administrator for the first time, the handicapped child must have been covered under the prior Claims Administrator and submit proof from the prior Claims Administrator that the child was covered as a handicapped person.

When The 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.

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 Claims Administrator. 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 limited 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator'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 Claims Administrator 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 Claims Administrator'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 Claims Administrator 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.

■ 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, Claims Administrator 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 Claims Administrator, 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 Claims Administrator 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 Claims Administrator will compensate In-Network Facility Providers in accordance with the contracts entered into between such Providers and the Claims Administrator. 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 Claims Administrator may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network.

The Claims Administrator 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 Claims Administrator 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 Claims Administrator. 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator for determination. The decision of the Claims Administrator shall be final.

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

➤ **Emergency Care by Out-of-Network Providers**

If the Claims Administrator 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 Claims Administrator 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 Claims Administrator. 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator'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 Claims Administrator'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 Claims Administrator 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 Claims Administrator will compensate In-Network Ancillary Service Providers in the Personal Choice Network in accordance with the contracts entered into between such Providers and the

Claims Administrator. 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 Claims Administrator's payment and the Out-of-Network Ancillary Service Provider's charge.

- **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

The Claims Administrator 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 the Claims Administrator 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 the Claims Administrator's service area, the Member will receive it from one of two kinds of 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. the Claims Administrator explains below how the Claims Administrator 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 the Claims Administrator 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, the Claims Administrator 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 the Claims Administrator'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 the Claims Administrator.

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 the Claims Administrator 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 the Claims Administrator through average pricing or fee schedule adjustments.

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

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

- Nonparticipating Providers Outside the Claims Administrator's Service Area

➤ Member Liability Calculation

When Covered Services are provided outside of the Claims Administrator'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 the Claims Administrator 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, the Claims Administrator 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 the Claims Administrator 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 the Claims Administrator 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 the Claims Administrator 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 Claims Administrator'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 Claims Administrator'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 Claims Administrator'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 Claims Administrator 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 Claims Administrator 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 Claims Administrator's local Personal Choice Network service area, the Claims Administrator 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 Claims Administrator; 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 Claims Administrator prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Claims Administrator 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 Claims Administrator 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.

■ Emergency Admission Review

- In-Network Admissions

It is the responsibility of the In-Network Provider to notify the Claims Administrator of the In-Network Emergency admission.

- Out-of-Network Provider Admissions

- Members are responsible for notifying the Claims Administrator 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 Claims Administrator.
- 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 Claims Administrator 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.

■ Concurrent and Retrospective Review

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Necessary. When performed, the review assesses the level of care provided to the 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator'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 Claims Administrator reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("Selective Medical Review") that are otherwise not

subject to review as described above. In addition, the Claims Administrator reserves the right to waive medical review for certain Covered Services for certain Providers, if the Claims Administrator determines that those Providers have an established record of meeting the utilization and/or quality management standards for 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 Claims Administrator 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 Claims Administrator 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. In certain circumstances the requirement for precertification may be altered or waived at the discretion of the Claims Administrator. The Claims Administrator may retrospectively review these services.

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

■ In-Network Care

In-Network Providers in the Personal Choice Network must contact the Claims Administrator to initiate Precertification. The Claims Administrator 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 Claims Administrator 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 Claims Administrator to initiate Precertification. The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator that they have declined participation;
- The Claims Administrator determines that the program, or aspects of the program, will not continue; or
- The Member's Employer decides not to offer the programs.

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 Claims Administrator 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 QCC Insurance Company's ("the Claims Administrator") 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 Claims Administrator in making coverage determinations for requested health care services, the Claims Administrator 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 Claims Administrator to be Medically Necessary and automatically approved based on the accepted Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an Emergency room which has been approved by the Claims Administrator based on the procedure meeting Emergency criteria and the severity of diagnosis reported (For example, rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed 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 Claims Administrator follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval using the Claims Administrator's Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Claims Administrator 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 Claims Administrator's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Necessity by providing Physicians with direct access to the Claims Administrator'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 Claims Administrator does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

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 Claims Administrator 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 Claims Administrator's plan determinations for similar medical issues and requests, and reduces practice variation among the Claims Administrator's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following:

- Some elective surgeries-settings for Inpatient and Outpatient procedures (For example, hysterectomy and sinus Surgery);
- Inpatient 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 QCC) Internally Developed Guidelines: A set of guidelines developed specifically by IBC (and QCC), as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting IBC Medical Policies for coverage.

Delegation of Utilization Review Activities And Criteria

In certain instances, the Claims Administrator 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 Claims Administrator'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 QCC) to a behavioral health management company, which administers the mental

health/psychiatric care and Alcohol and Drug Abuse benefits for the majority of the Claims Administrator'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 Claims Administrator and the other Plan in order to avoid duplication of benefits.

Benefits under this Program will be provided in full when the Claims Administrator is primary, that is, when the Claims Administrator determines benefits first. If another Plan is primary, the Claims Administrator 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 Claims Administrator's Plan is secondary, the benefits under this Program will be reduced so that the Claims Administrator 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 Claims Administrator payment exceed the amount that would have been payable under this Program if the Claims Administrator 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 Claims Administrator has the right to decide which facts are needed. The Claims Administrator may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which the Claims Administrator deems necessary for such purposes. Any person claiming benefits under this Program shall furnish to the Claims Administrator such information as may be necessary to implement this provision. The Claims Administrator, 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator shall be fully discharged from liability under this Program.

Whenever payments have been made by the Claims Administrator 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 Claims Administrator shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Claims Administrator shall determine:

- The person the Claims Administrator 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 Claims Administrator.

SUBROGATION AND REIMBURSEMENT RIGHTS

By accepting benefits for Covered Services, the Member agrees that the Claims Administrator has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of

each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Claims Administrator or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

Subrogation Rights

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

Reimbursement Rights

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

Lien

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

Constructive Trust

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

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

Obligations of Member

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

IMPORTANT: Failure to Cooperate

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

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 Claims Administrator'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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request.

The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator will not be liable under this Program unless proper notice is furnished to the Claims Administrator 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 Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator to be equitably entitled thereto. Any payment made by the Claims Administrator in good faith pursuant to this provision shall fully discharge the Claims Administrator to the extent of such payment.

Physical Examinations and Autopsy

The Claims Administrator 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 Claims Administrator 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 Claims Administrator, the Claims Administrator may on a selective basis, waive certain procedural requirements or cost-sharing of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Claims Administrator shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Claims Administrator nor the Providers in the Claims Administrator'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 Claims Administrator and appropriate regulatory authority, are extraordinary circumstances not within the control of the Claims Administrator, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot;
- Civil insurrection; or
- Public health emergency.

COMPLAINT AND APPEAL PROCESS

Member Complaint Process

The Claims Administrator has a process for Members to express complaints. To register a Complaint, Members should call the Member Services Department at the telephone number on their Identification Card or write to the Claims Administrator at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

Member Appeal Process

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

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

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820

Toll Free Phone: 1-888-671-5276 (TTY: 711)
Toll Free Fax: 1-888-671-5274 or
Phila. Fax: 215-988-6558

Changes in Member Appeals Process. Please note that the Member Appeals process 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 process, or to reflect other decisions regarding the administration of Member Appeals process for this Program.

Copies of the Member Appeals Process Descriptions. Descriptions of the timeframes and procedures for the Member Appeals process maintained by the Claims Administrator are available from the following sources:

On the Internet at the Website for the Member's Health Plan. Copies are available there at any time. To see samples of the Member Appeals process, search for "member appeals" in the general search engine. To review a description of the Member Appeals process for the Member's health plan, the Member must log in with the Member's personalized password.

Customer Service. To obtain a description of the Member Appeals process for the Member's health plan, call Customer Service at the telephone number listed on the Member's Identification Card. Customer Service will mail the Member a copy of the description.

When an Appeal is Filed. As part of the Member Appeal process, a description is provided for the type of Member Appeal that has been filed. The description is sent with the acknowledgment letter for the Member Appeal.

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.

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 Claims Administrator.

It is also a Facility Provider which:

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

Ancillary Service Provider

An individual or entity that provides Covered Services, supplies or equipment such as, but not limited to:

- 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

A request by a Member, or the Member's representative or Provider, acting on the Member's behalf upon written consent, to change a previous decision made by the Claims Administrator.

- **Administrative Appeal:** An Appeal by or on behalf of a Member that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative Appeal may present issues related to Medical Necessity, but these are not the primary issues that affect the outcome of the Appeal.
- **Medical Necessity Appeal:** A request for the Claims Administrator to change its decision, based primarily on Medical Necessity, to deny or limit the provision of a Covered Service.
- **Expedited Appeal:** A faster review of a Medical Necessity Appeal, conducted when the Claims Administrator determines that a delay in decision making would seriously jeopardize the Member's life, health, or ability to regain maximum function.

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 Claims Administrator.

Attention Deficit Disorder

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

Autism Service Provider

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

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

An Autism Service Provider shall include a Behavioral Specialist.

Autism Spectrum Disorders (ASD)

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

Autism Spectrum Disorders Treatment Plan (ASD Treatment Plan)

A plan for the treatment of Autism Spectrum Disorders:

- Developed by: A licensed Physician or licensed Psychologist who is a 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 Claims Administrator. 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 Claims Administrator 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.

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 entrestomal therapy nurse;
- A certified community health nurse;
- A certified psychiatric mental health nurse; or
- A certified clinical nurse specialist.

This excludes any registered professional nurses employed by:

- A health care facility; or
- An anesthesiology group.

Cognitive 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 Claims Administrator to determine if a prescription drug should be covered. Compendia provide:

- Summaries of how drugs work;
- Information about which drugs are recommended to treat specific diseases; and
- The appropriate dosing schedule for each drug.

Over the years, some Compendia have merged with other publications. The Claims Administrator only reviews current Compendia when making coverage decisions.

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.

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 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 Claims Administrator.
 - For Covered Services provided by an In-Network Facility or BlueCard Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with the Claims Administrator or the BlueCard Provider.
 - 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 Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator'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 Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator's applicable proprietary fee schedule, the amount is determined by the applicable Claims Administrator'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 Claims Administrator, 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 Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator'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 Claims Administrator 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 Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator'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.

- Nothing in this section shall be construed to mean that the Claims Administrator 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 Claims Administrator.

Custodial Care (Domiciliary Care)

Care provided primarily for Maintenance of the patient or care which is designed essentially:

- To assist the patient in meeting their activities of daily living; and
- Which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Custodial Care includes help in tasks which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

Such tasks include, but are not limited to:

- Walking;
- Bathing;
- Dressing;
- Feeding;
- Preparation of special diets; and
- Supervision over self-administration of medications.

Day Rehabilitation Program

A level of Outpatient Care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week.

The Member returns home:

- Each evening; and
- For the entire weekend.

Therapies provided may include a combination of therapies, such as:

- Physical Therapy;
- Occupational Therapy; and
- Speech Therapy.

Other medical services such as:

- Nursing services;
- Psychological therapy; and
- Case Management services.

Day Rehabilitation sessions also include a combination of:

- One-to-one therapy; and
- Group therapy.

Decision Support

Services that help Members make well-informed decisions about Health care and support their ability to follow their 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 Claims Administrator will assume any liability.

- A specific dollar amount that the Member's Claims Administrator 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.

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; | ■ Home oxygen equipment; |
| ■ Canes; | ■ Hospital beds; |
| ■ Crutches; | ■ Traction equipment; and |
| ■ Walkers; | ■ Wheelchairs. |
| ■ Commode chairs; | |

Effective Date

The date on which coverage for a Member begins under the Program. All coverage begins at 12:01 a.m. on the date reflected on the records of the Claims Administrator.

Emergency

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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

Gene Replacement Therapy

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

Group or (Enrolled Group)

A group of Employees which has been accepted by the Claims Administrator, 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 Claims Administrator.

Hearing Aid

A Prosthetic 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 Claims Administrator, 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 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 Claims Administrator, 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 Claims Administrator.

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 Claims Administrator 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.

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 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 or Ancillary Service Provider 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 Claims Administrator 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.

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.

Nutritional Formula

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

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 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 or Ancillary Service Provider 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, Deductibles, Penalties, or amounts that exceed the Claims Administrator'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 Claims Administrator 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.

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 Claims Administrator 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 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 Claims Administrator that proposed services, such as maternity care, are scheduled to be performed.

- No Penalty will be applied for failure to comply with this requirement.
- Payment for services depends on whether the Member and the category of service are covered under this Program.
- To Prenotify, the Member should call the telephone number on the ID card, prior to obtaining the proposed service.

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 Claims Administrator.

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 Claims Administrator, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness.

- Such services are provided by or under the supervision of an organized staff of Physicians.
- Continuous nursing services are provided under the supervision of a Registered Nurse.

Psychologist

A Psychologist who is:

- Licensed in the state in which they practice; or
- Otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

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 Claims Administrator 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 Claims Administrator, which is primarily engaged in providing rehabilitation care services on an Inpatient basis.

- Rehabilitation care services consist of:
 - The combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability.
- Services are provided by or under:
 - The supervision of an organized staff of Physicians.
- Continuous nursing services are provided:
 - Under the supervision of a Registered Nurse.

Reliable Evidence

Peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication, in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative.

Furthermore, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

Residential Treatment Facility

A Facility Provider licensed and approved by the appropriate government agency and approved by the Claims Administrator, which provides treatment for:

- Mental Illness;
- Serious Mental Illness; or
- Alcohol Or Drug Abuse And Dependency to partial, Outpatient or live-in patients who do not require acute Medical Care.

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 Claims Administrator and which is designed to handle the following kinds of procedures on an Outpatient basis:

- Lengthy diagnostic procedures; or
- Minor surgical procedures.

In the absence of a Short Procedure Unit these are procedures which would otherwise have resulted in an Inpatient Admission.

Skilled Nursing Facility

An institution or a distinct part of an institution, other than one which:

- Is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol Or Drug Abuse And Dependency.

It is also an institution which:

- Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- Is otherwise acceptable to the Claims Administrator.

Sleep Studies

Refers to the continuous and simultaneous monitoring and recording of various physiologic and pathophysiologic sleep parameters. Sleep tests are performed to:

- Diagnose sleep disorders (For example, narcolepsy, sleep apnea, parasomnias);
- Initiate treatment for a sleep disorder; and/or
- Evaluate an individual's response to therapies such as continuous positive airway pressure (CPAP) or bi-level positive airway pressure device (BPAP).

Sound Natural Teeth

Teeth that are:

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

Specialist Services

All Professional Provider services providing Medical Care or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Drug

A medication that meets certain criteria including, but not limited to:

- The drug is used in the treatment of a rare, complex, or chronic disease.
- A high level of involvement is required by a 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator.

■ 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.

■ Orthoptic/Pleoptic Therapy

Medically prescribed treatment for the correction of oculomotor dysfunction resulting in the lack of vision depth perception.

Such dysfunction results from:

- Vision disorder;
- Eye Surgery; or
- Injury.

Treatment involves a program which includes evaluation and training sessions.

■ Physical Therapy

Medically prescribed treatment of physical disabilities or impairments resulting from:

- Disease;
- Injury;
- Congenital anomaly; or
- Prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving:
 - 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator only covers treatment which it determines Medically Necessary. An In-Network Provider accepts the Claims Administrator's decision and contractually is not permitted to bill the Member for treatment which the Claims Administrator 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 Claims Administrator, and that the Member will be financially responsible for such services. An Out-of-Network Provider, however, is not obligated to accept the Claims Administrator's determination and the Member may not be reimbursed for treatment which the Claims Administrator 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 Member's care. The term "Medically Necessary" is defined in the *Important Definitions* section.

Regarding Treatment for Cosmetic Purposes:

The Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator researches all scientific information available from these expert sources. Following this analysis, the Claims Administrator makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Member or their Provider should contact the Claims Administrator to determine whether a proposed treatment is considered "emerging technology" and whether the Provider is considered an eligible Provider to perform the "emerging technology" Covered Service. The Claims Administrator maintains the discretion to limit eligible Providers for certain "emerging technology" Covered Services.

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 Claims Administrator 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 Claims Administrator'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 Claims Administrator 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;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Discretionary Authority

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

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 Claims Administrator for a coverage determination. That way the Member and the Provider will know in advance if the treatment will be covered by the Claims Administrator.

In the event the treatment is not covered by the Claims Administrator, 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 Claims Administrator 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.

LANGUAGE AND COVERAGE CHANGES

QCC INSURANCE COMPANY

2023 PREVENTIVE SCHEDULE

This schedule is a reference tool for planning your preventive care and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. In accordance with the PPACA, the schedule is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force, Health Resources and Services Administration, U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 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 health care provider is always your best resource for determining if you are at increased risk for a condition. Some services may require precertification/preapproval. If you have questions about this schedule, precertification/preapproval, or your benefit coverage, please call the Customer Service number on the back of your ID card.

PREVENTIVE CARE SERVICES FOR ADULTS

VISITS	
Preventive exams Services that may be provided during the preventive exam include but are not limited to the following: <ul style="list-style-type: none"> • High blood pressure screening • Behavioral counseling for skin cancer • Obesity Screening • Unhealthy drug use screening 	One exam annually for all adults
SCREENINGS	
Abdominal aortic aneurysm (AAA) screening	Once in a lifetime for asymptomatic males age 65 to 75 years with a history of smoking
Prediabetes and Type 2 diabetes mellitus screening and intensive counseling interventions	Abnormal blood glucose and type 2 diabetes screening for adults 35 to 70 years who are overweight or obese Intensive behavioral counseling interventions for individuals 35 to 70 years who are overweight or obese with abnormal blood glucose up to 32 sessions per year
Colorectal cancer screening	Adults age 45 to 75 years using any of the following tests: <ul style="list-style-type: none"> • Fecal occult blood testing: once a year • Highly sensitive fecal immunochemical testing: once a year • Flexible sigmoidoscopy: once every five years • CT colonography: once every five years • Stool DNA testing: once every three years • Colonoscopy: once every 10 years

Depression screening	Annually for all adults
Hepatitis B virus (HBV) screening	All asymptomatic adults at high risk for HBV infection
Hepatitis C virus (HCV) screening	All asymptomatic adults
High Blood Pressure Screening	Adults age 18 years or older with increased risk once a year Adults age 18 to 39 years with no other risk factors once every 3 to 5 years Adults age 40 years once a year
Human immunodeficiency virus (HIV) screening	All adults
Latent tuberculosis infection screening	Asymptomatic adults age 18 years or older at increased risk for tuberculosis
Lipid disorder screening	Adults 40 years or older once every 5 years
Lung cancer screening	Adults age 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
Syphilis infection screening	All adults at increased risk for syphilis infection
Unhealthy alcohol use screening and behavioral counseling interventions	Screening for all adults not diagnosed with alcohol abuse or dependence or not seeking treatment for alcohol abuse or dependence Behavioral counseling in a primary care setting for individuals with a positive screening result
THERAPY AND COUNSELING	
Behavioral counseling for prevention of sexually transmitted infections	All sexually active adults
Behavioral interventions for weight loss	Behavioral intervention for adults with a body mass index (BMI) of 30kg/m ² or higher
Exercise Interventions for the prevention of falls	Community-dwelling adults age 65 years and older with an increased risk of falls
Intensive behavioral counseling interventions to promote a healthful diet and physical activities for cardiovascular disease prevention	Adults age 18 years and older diagnosed as overweight or obese with known cardiovascular disease risk factors
Nutritional counseling for weight management	6 visits per year
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 age 45 years and older when used in conjunction with a preventive colorectal cancer screening procedure (That is, flexible sigmoidoscopy, colonoscopy, virtual colonoscopy)

Statin	Adults age 40 to 75 with no history of cardiovascular disease, with one or more risk factors for cardiovascular disease and a 10-year cardiovascular disease event risk of greater than 10%
Tobacco cessation medication	All adults who use tobacco products

IMMUNIZATIONS	
Adult Immunization Schedule: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf	

PREVENTIVE CARE SERVICES FOR FEMALES, INCLUDING PREGNANT FEMALES

VISITS	
<p>Prenatal/Postpartum Care Visits</p> <p>Services that may be provided during the prenatal/postpartum care visits include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Preeclampsia Screening 	For all pregnant females
<p>Well-woman visits</p> <p>Services that may be provided during the well-woman visit include but are not limited to the following:</p> <ul style="list-style-type: none"> • BRCA-related cancer risk assessment • Discussion of chemoprevention for breast cancer • 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
Counseling Interventions to Prevent Perinatal Depression	<p>Pregnant or postpartum females at increased risk for perinatal depression without a current diagnosis of depression</p> <p>20 sessions over a 70-week period</p>
BRCA-related cancer risk assessment, genetic counseling, and BRCA mutation testing	<p>Genetic counseling for asymptomatic females with an ancestry associated with BRCA gene mutations, personal history or family history of a BRCA-related cancer</p> <p>BRCA mutation testing, as indicated, following genetic counseling</p>
Breast cancer screening (2D or 3D mammography)	All females age 40 years and older

Cervical cancer screening (Pap test)	Age 21 to 65: Every three years Age 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 screening	Sexually active females age 24 years and younger or older sexually active females who are at increased risk for infection
Diabetes Mellitus 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 Screening	All pregnant and post-partum females
Gestational diabetes mellitus screening	Asymptomatic pregnant females after 24 weeks of gestation who have not been diagnosed with diabetes or at the first prenatal visit for pregnant females identified to be at high risk for diabetes
Gonorrhea screening	Sexually active females age 24 years and younger or older sexually active females who are at increased risk for infection
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
Human papillomavirus (HPV) screening	Age 30 and older: Every five years Ages 30 to 65: Every five 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 two years for females younger than 65 years who are at increased risk for osteoporosis Every two years for females 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
Behavioral counseling for sexually transmitted infections	For all sexually active adolescents and adults at increased risk
Counseling for the prevention of obesity	For females age 40 to 60 years with a normal or overweight BMI
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 age 35 years and older without a prior diagnosis of breast cancer, or ductal 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 including breast milk storage supplies
Reproductive education and counseling, contraception, and sterilization	All females with reproductive capacity

PREVENTIVE CARE SERVICES FOR CHILDREN

VISITS	
Pre-birth 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: <ul style="list-style-type: none"> • 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 21 years of age, with preventive exams provided at: <ul style="list-style-type: none"> • 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 11 years of age and older Annual behavioral counseling in a primary care setting for children with a positive screening result for drug or alcohol use/misuse
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 age 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 metabolic 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
Obesity Screening and Behavioral Counseling	Screening is part of the preventive exam for children age 6 years and older. Behavioral counseling for children age 6 years and older with an age- and sex-specific body mass index (BMI) in the 95 th percentile or greater
MEDICATIONS	
Fluoride	Oral fluoride for children age 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 three months for all infants and children starting at age of primary tooth eruption to 5 years of age
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

Independence 

Benefits underwritten or administered by QCC Ins. Co., a subsidiary of Independence Blue Cross ®
Independent Licensees of the Blue Cross and Blue Shield Association.

QCC INSURANCE COMPANY
(Hereafter called "The Claims Administrator")

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

VISION CARE PROGRAM

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilfigriege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian:

សូមមេត្តាចាប់អារម្មណ៍: ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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 differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these 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. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Vision Care Coverage

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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	One every two (2) calendar years.
Coinsurance	None
Benefit Period Maximum (Participating)	\$20 Copayment for all Covered Services.
Benefit Period Maximum (Non-Participating)	\$35 for all Covered Services.

SCHEDULE OF COVERED SERVICES

COVERED SERVICES

**AMOUNTS PAYABLE AND LIMITATIONS
ON COVERED SERVICES**

	<u>Participating*</u>	<u>Non-Participating</u>
Eye examination, including refraction and glaucoma screening and dilation, as professionally indicated.	100% of the Provider's Reasonable Charge.	100% of the Provider's Reasonable Charge, up to a Maximum of \$35.
Spectacle Lenses		
• All ranges of prescriptions, oversize lenses, plastic lenses, single vision, lined bifocal, lined trifocal or lenticular lenses	100%	
• Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters	100%	
• Glass grey #3 prescription sunglass lenses	100%	
• Tinting	100%	
Frames		
- Plan supplied:	100%, with a Copayment of:	
• Fashion selection	\$0	Not Covered
• Designer selection	\$0	Not Covered
• Premier selection	\$20	Not Covered
OR		
- Doctor supplied:	100%, up to a Maximum of \$60	100%, up to a Maximum of \$75
OR		
- Visionworks supplied:	100%, up to a Maximum of \$60	Not Covered
Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses and Evaluation and Fitting	100%, up to a Maximum of \$0	

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 Claims Administrator 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 Vision Care Program administered by QCC Insurance Company.

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 Claims Administrator.

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 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 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 Plan, 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;
- Other than specifically provided in the section entitled ***Vision Care Benefits*** of this Booklet.

SECTION 4 - WHO IS COVERED

Eligible Person

- Eligible Person is defined as a Member who is determined by the Group as eligible to apply for coverage and sign the Application; and
- Eligible Dependents as specified to the Claims Administrator by the Group 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 Program Document. 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 Claims Administrator 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 Claims Administrator approved by the Department of Military & Veterans Affairs (DMVA):

- Notifying the Claims Administrator that the Dependent has been placed on active duty;
 - Notifying the Claims Administrator that the Dependent is no longer on active duty;
 - Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after his 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 Program Document. The Claims Administrator 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.

Effective Date

The date the Group agrees that all Eligible Persons may apply and become covered. If a person becomes an Eligible Person after the Group's Effective Date, that date becomes the Effective Date.

SECTION 5 - GENERAL INFORMATION

Benefits To Which Members Are Entitled

- The liability of the Claims Administrator is limited to the benefits specified in the Group Program Document.
- 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 Claims Administrator before the Claims Administrator receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Claims Administrator will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Group notified the Claims Administrator 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 Program Document 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 Program Document ends.

The Claims Administrator will provide benefits under the Group Program Document during an extension as if the person were still a Member. In addition, the Claims Administrator will provide benefits only to the extent that other coverage for the Covered Services is not provided for the by the Group. Continuation of coverage is subject to payment of the applicable premium.

When You Terminate Employment - Continuation Of Coverage Provisions - Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or the Employee's eligible Dependents to temporarily extend health care coverage.

Continuation Of Incapacitated Child

If 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 Claims Administrator to continue coverage of such child under this Program upon such terms and conditions as the Claims Administrator may determine. Coverage of such Dependent child shall terminate upon the child's marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 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 Claims Administrator for the first time, the handicapped child must have been covered under the prior Claims Administrator and submit proof from the prior Claims Administrator that the child was covered as a handicapped person.

Timely Filing

The Claims Administrator will not be liable under this Program unless proper notice is furnished to the Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator 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 Claims Administrator, upon its request, any information (including copies of records) relating to the illness or injury. In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request. The Claims Administrator shall provide to the Group, at the Group's request, any and all information regarding claims and charges submitted to the Claims Administrator by Professional Providers. The Parties understand that any information provided to the Group will be adjusted by the Claims Administrator to prevent the disclosure of the identity of any Member or other patient treated by said Professional Providers. The Group shall reimburse the Claims Administrator for the actual costs of preparing and providing said information. The Claims Administrator shall provide the Group with such cost figure and obtain the Group's approval of such expense prior to incurring such costs.

The Claims Administrator may also furnish membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Claims Administrator 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 Claims Administrator 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 Claims Administrator will furnish to the Member making the claim, or to the Group, 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 Claims Administrator should pay for any contractually excluded services through inadvertence or error, the Claims Administrator 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 Claims Administrator does not furnish Covered Services but only makes payment for Covered Services received by Members. The Claims Administrator is not liable for any act or omission of any Professional Provider or Supplier. The Claims Administrator has no responsibility for a Professional Provider's or Supplier's failure or refusal to render Covered Services to a Member.

Agency Relationships

The Group is the agent of the Member, not the Claims Administrator.

Identification Cards And Benefit Booklets

The Claims Administrator will provide the Identification Cards to Members or to the Group, depending on the direction of the Group. The Claims Administrator will also provide to each Member of an Enrolled Group a Benefit Booklet describing the benefits provided under the Group Program Document.

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 Program Document must be in writing. Notice given to a Member will be given to the Member in care of the Group, or sent to the Member's last address furnished to the Claims Administrator by the Group. The Group, the Claims Administrator, or a Member may, by written notice, indicate a new address for giving notice.

Subrogation and Reimbursement Rights

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

The Claims Administrator or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

■ Subrogation Rights

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

■ Reimbursement Rights

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

■ Lien

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

■ Constructive Trust

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

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

■ Obligations of Member

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

IMPORTANT: Failure to Cooperate

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

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 Claims Administrator, the Claims Administrator may on a selective basis, waive certain procedural requirements or cost-sharing of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Claims Administrator shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Claims Administrator nor the 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 Claims Administrator and appropriate regulatory authority, are extraordinary circumstances not within the control of the Claims Administrator, including but not limited to:

- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot;
- Civil insurrection; or
- Public health emergency.

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;
- 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 (COMPLAINTS/APPEALS)

Member Complaint Process

The Claims Administrator has a process for Members to express informal complaints. To register a complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Claims Administrator at the following address:

Independence Blue Cross
General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

Member Appeal Process

■ Filing an Appeal

The Claims Administrator maintains procedures for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Claims Administrator stating an adverse benefit determination. An appeal occurs when the Member or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. In order to authorize someone else to be the Member's representative for the appeal, the Member must complete a valid authorization form. Contact the Claims Administrator as directed below to obtain a form for a member/enrollee to authorize an appeal by a Professional Provider or other representative or for questions regarding the requirements for an authorized representative.

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

Member Appeals Department
P.O. Box 41820
Philadelphia, PA, 19101-1820.

Toll Free Phone: 1-888-671-5276
Toll Free Fax: 1-888-671-5274 or
Phila. Fax: 215-988-6558

■ Types of Member Appeals and Timeframe Classifications

Following are the two types of Member appeals and the issues they address:

- Medical Necessity Appeal Issues – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for experimental/investigative or cosmetic services.
- Administrative Appeal Issues – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

- Standard Pre-service appeal - An appeal for benefits that, under the terms of the Program, must be precertified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available.
- Standard Post-service appeal - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)
- Expedited/Urgent appeal – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Claims Administrator will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member’s life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

■ Information for the Appeal Review including Matched Specialist’s Report

The Member may submit to the Claims Administrator additional information pertaining to the Member’s case. The Member may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, the Claims Administrator will provide the Member or the Member’s authorized representative access to, and copies of, documents, records, and other information relevant to the appeal that is provided for the appeal decision maker(s) to review.

Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed Physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

■ Appeal Committee Composition and Role

Each Appeals Committee described below will be comprised of one to three persons designated by the Claims Administrator to act as decision maker(s) on the appeal. The Committee decision maker(s) did not make the adverse benefit determination at issue in the appeal and are not subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or the Member’s authorized representative or obtained from other sources during the investigation of the appeal issues.

STANDARD APPEALS: Process and timeframes

An acknowledgement letter and description of the appeal process is mailed following receipt of a Member appeal. A standard consists of one level of internal review for which evaluation and decision must be completed within the following timeframes:

- Standard Pre-service Appeal - within 30 days of receipt of the appeal request.
- Standard Post-service Appeal - within 60 days of receipt of the appeal request.

The appeal review will occur based on the information available for the Appeal Committee’s review. The Member is encouraged to supply additional relevant information to the appeals specialist preparing the appeal.

Written notice of the standard appeal decision will be sent within the timeframes stated above. If the appeal is denied, the decision notice will state the specific reason for the denial, refer to Program provision(s) and guidelines on which the decision is made, tell the Member about relevant information that is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to the Member.

The standard appeal decision is final with respect to the Member’s right to appeal through the Claims Administrator’s internal member appeal process.

EXPEDITED APPEALS: Process and timeframes

If a case involves a serious medical condition which the Member believes may jeopardize the life, health, ability to regain maximum function, or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision, the Member may ask to have the case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframe:

- **Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.**

To request an expedited appeal by the Claims Administrator, call or fax the Member Appeals Department at the phone numbers listed above under "Filing an Appeal." Information related to an appeal will be requested and the Member will be promptly informed whether it qualifies for review as an expedited appeal or must instead be processed as a standard appeal.

The Expedited Appeal Committee will review all relevant information for the appeal from the Member or their authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an expedited appeal. The Member is encouraged to supply additional relevant information to the appeals specialist preparing the appeal.

The Expedited Appeal review will be completed promptly based on a Member's health condition, but no later than 72 hours after receipt of the expedited appeal by the Claims Administrator. The Member will be notified of the decision by telephone and a letter mailed in no more than 72 hours. If the appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell the Member that relevant information is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to the Member. The expedited appeal decision is then final with respect to a Member's right to appeal through the Claims Administrator's internal appeal process.

The policy and procedures for Member appeals may change due to changes that the Claims Administrator makes to comply with applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting agencies, or to otherwise improve the Member Appeals process.

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 conferment 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.

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 Claims Administrator. 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 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 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.

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*.

Effective Date

A date on which coverage for a Member begins under the Group Program Document.

Employee

An individual in the Group 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 Claims Administrator 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 Claims Administrator for Covered Services.
- Benefit Maximum - the greatest amount payable by the Claims Administrator for a specific Covered Service.

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 Claims Administrator's programs and is not required to accept the Claims Administrator'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 patient'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 Provider that has an agreement with the Claims Administrator pertaining to payment for Covered Services rendered to a Covered Person.

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 Claims Administrator. 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 Claims Administrator 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.