We would like to thank you for joining Personal Choice®. Carrying a Personal Choice ID card entitles you to coverage for a variety of benefits and preventive care and access to a large network of doctors, hospitals and other health care providers. In addition to in-network providers, you also have the freedom to access a national network of BlueCard® PPO providers, or you can choose an out-of-network provider.

To get the most from Personal Choice, it’s important to become familiar with the benefits and services available to you. You’ll find this valuable information in this Welcome Kit, which you should keep handy for future reference.

Your Personal Choice ID Card(s) will be mailed separately. Please check your card(s) carefully to be sure the information is accurate. You will need to use your card each time you visit your doctor, specialist, hospital or other health care provider.

If you need additional information, or have questions about your Personal Choice coverage, please call the Customer Service Department telephone number located on our ID card.

Sincerely,

Renee J. Rhem
Director
Customer Service
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Any questions? Call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at [www.ibx.com](http://www.ibx.com).
Introduction to Personal Choice®

Welcome to Personal Choice…the Health Plan of Choice

Personal Choice is a managed care plan designed by Independence Blue Cross to provide you with comprehensive benefits and preventive care, at the same time giving you the freedom of choice to select your own doctors and hospitals.

Personal Choice is dedicated to keeping you and your family healthy through preventive care services such as routine physical examinations, immunizations and well-child care. (Please see your benefit booklet or contract for a detailed description of your preventive benefits).

At Independence Blue Cross we want you to understand your Personal Choice plan. We have developed this Member Handbook to explain your Personal Choice benefits, so that you can take full advantage of your new health care plan.

If you have questions about any aspect of your coverage, call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583).

What is a Preferred Provider Organization (PPO)?

Personal Choice is a Preferred Provider Organization, or PPO. You will receive the highest level of benefits when you receive care through a “preferred” (network) doctor or hospital.

A PPO like Personal Choice offers you the freedom to choose your own physicians like a traditional health care plan, and the low-cost physician visits and preventive benefits normally associated with a Health Maintenance Organization (HMO). There are several significant differences, however, between a PPO and an HMO. With a PPO like Personal Choice:

• You are not required to select a primary care physician to coordinate your care; and
• You are not required to obtain referrals to see specialists.

How Does Personal Choice Work?

With Personal Choice, you have access to a network of doctors, hospitals and other health care providers. These providers belong to the Personal Choice Network or participate in other Blue Cross and Blue Shield Plans’ BlueCard PPO networks. The Personal Choice Network service area includes Bucks, Chester, Delaware, Montgomery and Philadelphia and adjacent counties (Berks, Lancaster, Lehigh and Northampton in Pennsylvania; Burlington, Camden, Gloucester, Hunterdon, Mercer, Salem and Warren in New Jersey; New Castle County in Delaware; and Cecil County in Maryland).

When you choose network providers you will generally receive the highest level of benefits with the lowest out-of-pocket expense.

You will still receive benefits for covered services if you choose to use a health care provider that is not a network provider. However, you will have higher out-of-pocket costs and may have to submit a claim for reimbursement.
What is BlueCard® PPO?
Through the BlueCard® PPO Program, Personal Choice members may access other Blue Cross®/Blue Shield® Plans’ BlueCard® PPO networks throughout the United States and receive in-network coverage. Whether you travel or live outside the Personal Choice Network service area, you will have access to in-network benefits when you use BlueCard® PPO providers in another Blue Plan’s BlueCard PPO network.

Your Personal Choice ID Card
Use your Personal Choice ID Card while you are a member to access health care services.
Listed below are some important things to do and to remember about your ID Card:
• Check the information on your ID Card for completeness and accuracy.
• Call Customer Service if you find an error or lose your ID Card.
• Carry your ID Card at all times. You must present your ID Card whenever you receive medical care.
There is important information on the back of your Personal Choice ID card about how to pre-authorize health care services, and telephone numbers that you, a doctor or hospital can use for questions about your coverage, or to obtain Precertification.

Your BlueCard® PPO Instruction Card
When you enroll in Personal Choice, you will receive a BlueCard PPO instruction card with your new ID card. The front of this instruction card explains how BlueCard PPO providers verify eligibility and benefits as well as how to submit your claims. The back of the instruction card provides important reminders for you about precertification requirements and how to find BlueCard PPO providers.

If you travel or live outside the Personal Choice Network service area, you should carry your BlueCard PPO instruction card with you and present it with your Personal Choice ID card when seeking care.

How to Find a Personal Choice Network Provider
For the most up-to-date information about Personal Choice Network providers, call the Health Resource Center at 1-800-ASK-BLUE (1-800-275-2583). You can call the Health Resource Center to obtain information about a provider’s qualifications, specialty, languages spoken, address and telephone number. The Health Resource Center can help you find Personal Choice Network providers that are close to your home or work place.

If a Personal Choice doctor directs you to another health care provider for specialized services, make sure you ask if they are a Personal Choice Network provider. If you are not sure whether a provider is a Personal Choice Network provider, or if you need help finding a Personal Choice Network provider, call the Health Resource Center at 1-800-ASK-BLUE (1-800-275-2583). You may also visit the Independence Blue Cross web site at www.ibx.com to find participating Personal Choice Network providers.
**How to Find a BlueCard® PPO Provider (if you travel or live outside the Personal Choice Network service area)**

If you need to find a BlueCard PPO doctor or hospital, call *BlueCard Access* at **1-800-810-BLUE (1-800-810-2583)**. A BlueCard representative will help you find the nearest BlueCard PPO doctor or hospital. You may also visit the BlueCard Doctor and Hospital Finder web site at [www.bcbs.com](http://www.bcbs.com) to find BlueCard PPO doctors, hospitals and other health care providers.

**How to Schedule an Appointment with your Network Provider**

It's easy! Simply call your doctor's office and request an appointment. There are no special rules to follow. Appointments are scheduled according to the type of medical care you request. Medical conditions requiring immediate attention are scheduled sooner.

If at all possible, please call network providers 24 hours in advance if you are unable to make it to a scheduled appointment.

**How to Access Care After Normal Office Hours**

If you need to access medical care or need urgent medical advice after your doctor's normal office hours, it's available 24 hours a day, 7 days a week. If an urgent issue arises after your doctor's normal office hours, call your doctor's office for instructions for contacting your doctor or a covering doctor.

**Members with Special Needs**

If you have a foreign language need…

Customer Service representatives will work with you through an interpreter over the telephone to help you understand your benefits and answer any questions you may have. Call Customer Service at **1-800-ASK-BLUE (1-800-275-2583)**.

If you have trouble hearing…

Our Customer Service representatives are available to assist you through TDD at **1-888-857-4816**.

**Using an Out-of-Network, Participating Blue Plan Provider**

You can typically reduce your out-of-pocket costs when using an out-of-network provider if you choose a physician or hospital that participates on a non-PPO basis with Highmark Blue Shield, or any of the Blue Cross and Blue Shield Plans throughout the U.S.

The coinsurance you pay will often be based on the lesser of the portion of the negotiated prices passed on by the other Blue Plan or the charges billed by these health care providers. If the non-PPO, participating Blue Cross/Blue Shield provider generally agrees to accept a negotiated price as full payment for covered services, you should not be billed for any balances. The non-PPO, participating Blue Cross/Blue Shield provider may bill you, however, for any deductible or coinsurance amounts required by your Plan.

Non-PPO participating Blue Cross/Blue Shield providers usually file claims for you, so you will probably not have to complete a claim form.

Any questions? Call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at [www.ibx.com](http://www.ibx.com).
**Using an Out-of-Network, Non-Participating Blue Plan Provider**

With Personal Choice, you will still receive benefits if you choose to go to a doctor, hospital or other health care provider that does not belong to the Personal Choice Network or does not participate in another Blue Plan’s BlueCard® PPO network.

When you use doctors and hospitals that are not in the Personal Choice Network or BlueCard® PPO program and do not participate on a non-PPO basis with any of the Blue Cross and Blue Shield Plans across the country, you may have to pay the full charges and submit a claim for reimbursement.

Out-of-network, non-participating providers may bill you for deductibles, coinsurance and the differences between the Plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant.

**How to Submit a Claim Step-by-Step**

**In-Network**

Personal Choice Network and BlueCard® PPO providers submit in-network claims on your behalf. You are not required to submit claim forms for in-network services.

**Out-of-Network**

When you use doctors and hospitals that are not in the Personal Choice Network or BlueCard® PPO program and do not participate on a non-PPO basis with any of the Blue Cross and Blue Shield Plans across the country, you may have to pay the full charges and submit a claim for reimbursement. You may also have to complete and submit a claim to receive payment for your medical expenses. Claims payments for out-of-network professional providers (physicians) are based on IBC’s own fee schedule.

**Claim Forms:** Out-of-network claim forms are included in your Personal Choice Welcome Kit. For additional claim forms, call Personal Choice Customer Service at **1-800-ASK-BLUE** (1-800-275-2583). Step by step instructions are outlined below, and are also listed on the back of the claim form for your convenience.

If you are submitting expenses for more than one family member, please use a separate claim form for each person.

**Note:** Keep a copy of the completed claim form and the itemized bills for your records.

**Step 1:** Complete the entire Personal Choice out-of-network claim form (have your doctor complete the appropriate section, if necessary).

**Step 2:** Attach itemized bills for the charges being submitted. Bills should include the name and address of the health care provider, type of service, date of service, the cost of services and the doctor's certification for the purchase or rental of durable medical equipment.

**Step 3:** When you have already paid the out-of-network doctor in full for the services or supplies you are claiming, please be sure to have the doctor mark “Paid in Full” clearly on the bills so that payment is made to you (if you are the subscriber).

**Step 4:** Return the completed claim form and itemized bills to the address on the claim form.

For questions about how your claim was paid, the status of your claim, or to question or appeal how a claim was paid, please call Customer Service at **1-800-ASK-BLUE** (1-800-275-2583).
What is an Emergency?

A medical emergency is typically thought of as a medical or psychiatric condition which presents acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or place one’s health in serious jeopardy. If you are experiencing symptoms that might reasonably indicate such a condition, then you may need emergency care and should go immediately to the closest emergency room of the nearest hospital. If you believe your situation is particularly severe, call 911 for assistance.

What to Do in an Emergency

It’s important to know the difference between urgent health care needs and those that are emergencies. Understanding this important difference helps you know when to go to the hospital emergency room, and when to seek care from your doctor.

Most times, a hospital emergency room is not the most appropriate place for you to be treated. Hospital emergency rooms provide emergency care and therefore must prioritize patients’ needs. The most seriously hurt or ill patients are treated first. If you are not in that category, you could wait a long time. In addition, many urgent conditions require follow-up care that is best provided or coordinated by the physician who knows you best—your doctor.

What is Urgent Care?

An urgent health care condition is one that should be treated within 24 hours, but does not need immediate treatment. If you are not sure if your condition is an emergency or that it may be urgent, call your doctor. He or she knows you and your medical history best and can best assess your condition. Based on your symptoms, your doctor may direct you to a hospital emergency department. Your doctor may also arrange to see you for an evaluation and treatment in the office, or perhaps suggest another option.

What to Do in an Emergency in the Personal Choice Network Service Area

If you experience acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or put your health in jeopardy, go to the emergency room of a nearby hospital. If you believe your situation is particularly severe, call 911 for assistance.

If you are admitted to the hospital because of an emergency, call 1-800-ASK-BLUE (1-800-275-2583) or Magellan Behavioral Health (for mental and substance abuse treatment) at the telephone number listed on your ID card within 48 hours of your admission.

What to Do in an Emergency When Outside the Personal Choice Network Service Area

You are covered for emergency care required when traveling. For out-of-area emergencies, go immediately to the nearest health care provider. If you are admitted to the hospital, contact 1-800-ASK-BLUE (1-800-275-2583) or Magellan Behavioral Health (for Mental Health and Substance Abuse) within 48 hours of your admission or as soon as possible at the precertification telephone number listed on your ID card.
**Personal Choice® Benefits**

**Personal Choice Covered Services***

With Personal Choice you get comprehensive benefits even when you use out-of-network providers. You have the added advantage of maximum coverage if you use Personal Choice Network or BlueCard® PPO providers. Covered services (in-network and out-of-network) include:

- Office Visits
- Hospital Care
- Allergy Testing and Treatment
- Diagnostic X-ray and Laboratory Services
- Durable Medical Equipment
- Maternity and Newborn Care
- Routine Gynecological Care
- Pediatric Immunizations
- Well-Child Exams
- Preventive Care (children and adults)
- Physical Therapy
- Surgery
- Skilled Nursing Facility Care
- Hospice and Home Health Care
- Mental Health and Substance Abuse Treatment**

Please refer to your benefit booklet or contract for the specifics of your Personal Choice plan. For questions about your coverage, call Personal Choice Customer Service at **1-800-ASK-BLUE** (1-800-275-2583).

**Services Not Covered by Personal Choice**

The easiest way to tell what Personal Choice will not cover is to check your benefit booklet or contract. You can also call Customer Service at **1-800-ASK-BLUE** (1-800-275-2583).

**How to Get the Most from Your Personal Choice Coverage**

To get the most out of your Personal Choice coverage, here’s an excellent rule of thumb: make sure you use health care providers who participate in the Personal Choice Network or another Blue Plan's BlueCard® PPO network. Using these providers is much more convenient and will keep your out-of-pocket costs to a minimum.

- For the most up-to-date information about Personal Choice Network providers, including a doctor’s qualifications, call the Health Resource Center at **1-800-ASK-BLUE** (1-800-275-2583).
- If you need information about BlueCard PPO providers, call BlueCard Access at **1-800-810-BLUE** (1-800-810-2583).
- **If you are not using a Personal Choice Network provider, you will have to obtain precertification yourself. Please call Personal Choice’s Care Management and Coordination team at the telephone number on your ID card.**
- Obtain precertification when necessary. For example, if you are scheduled for elective surgery—surgery that is planned ahead of time—or planning to obtain durable medical equipment such as a walker, a wheelchair or a hospital bed, in most cases we have to precertify your need. Check your benefit booklet or contract for services that require precertification.
- When in doubt about whether a particular treatment or service is covered or requires precertification, call Customer Service at **1-800-ASK-BLUE** (1-800-275-2583).

*Some services require precertification.

**Coverage of mental health and substance abuse benefits depends on the terms and conditions of your group health plan.

Any questions? Call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at [www.ibx.com](http://www.ibx.com).
Answering Your Questions About BlueCard® PPO

Q: Will I receive a special membership card for BlueCard® PPO?
A: No, your Personal Choice ID card with its “PPO in a suitcase” logo is the only card you need. Carry your Personal Choice ID card, and BlueCard PPO instruction card with you at all times, and present both cards to a BlueCard PPO provider or office manager when you receive medical care.

Q: How will a BlueCard PPO provider know I am eligible for the advantages of BlueCard?
A: The BlueCard PPO provider will look at your ID card for the “PPO in a suitcase logo.” When you arrive at the doctor’s office or hospital, present your ID card and the doctor or hospital will verify your membership and coverage information. Providers can use the BlueCard Eligibility number 1-800-676-BLUE (1-800-676-2583) to verify your coverage, eligibility and out-of-pocket costs (copayments, deductibles and coinsurance). The three-letter alpha-prefix that is in front of your ID number is also important to the provider; they will use this information to route your claim for payment.

Q: Do I need to obtain precertification or prior authorization, or will the doctor do this?
A: When you are out of the area, you are responsible for initiating precertification or prior authorization, if it is necessary for the service your doctor recommends. For example, if you are scheduled for elective surgery – surgery that is planned ahead of time – or you are planning to obtain durable medical equipment such as a walker, a wheelchair or a hospital bed, you should call Independence Blue Cross to initiate precertification. Check your booklet or contract for the services that require precertification or prior authorization. Precertification/prior authorization can be obtained by calling the precertification telephone number on your ID card.

In an emergency, seek immediate care from the nearest health care provider.

Q: Where do I call if I have questions about how my BlueCard PPO claim was paid?
A: You should call Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583).

Q: What if I need health care outside the United States?
A: When you need health care outside the U.S., follow these simple steps:

1. Take your Personal Choice ID card with you when you travel outside the U.S.
2. If you need non-emergency medical care, you must call the BlueCard Worldwide® Service Center at 1-800-810-BLUE (1-800-810-2583) or call collect at 1-804-673-1177. A medical assistance coordinator, in conjunction with a nurse, will facilitate hospitalization or make an appointment with a doctor.
3. Call Independence Blue Cross for precertification when necessary. Refer to the precertification telephone number on your ID card.

Any questions? Call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at www.ibx.com.
How to File a Claim for BlueCard Worldwide Services

• For **inpatient care** at a BlueCard Worldwide® hospital that was arranged through the BlueCard Worldwide® Service Center at 1-800-810-BLUE (1-800-810-2583), you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance). The provider files the claim for you.

• For all **outpatient and professional medical care**, you pay the provider and submit a claim. You may also have to pay the hospital (and submit a claim) for inpatient care obtained from a non-BlueCard Worldwide® hospital or when inpatient care was not arranged through the BlueCard Worldwide Service Center. **Covered outpatient and professional medical care are paid at the out-of-network level.**

• To submit a claim, complete an **International Claim Form** and send it to the BlueCard Worldwide® Service Center. A claim form will be sent to you as a result of your call to the BlueCard Worldwide® Service Center at 1-800-810-BLUE (1-800-810-2583).
**Mental Health and Substance Abuse Treatment**

Coverage of mental health and substance abuse depends on the terms and conditions of your group health plan. If your group health plan includes mental health and substance abuse benefits, you might be covered for certain treatments/services.

If you face with an emergency or have particularly severe symptoms, follow the procedures outlined in the “What To Do In An Emergency” section of this Welcome Kit. For emergency admissions to a facility, please contact the behavioral health care organization that administers your mental health and substance abuse benefits within two business days of the admission.

*Note: Your group may have contracted with an independent behavioral health vendor/organization, other than Independence Blue Cross, to coordinate and process claims for mental health/substance abuse treatments/services. If this is the case, your Independence Blue Cross health benefits plan does not provide coverage for your mental health and substance abuse benefits. If you have questions about the behavioral health management company that administers your benefits plan, please contact your Employer/Plan Administrator.*

See your benefits description materials for information about Independence Blue Cross precertification requirements that might apply to mental health and substance abuse services/treatments.
Precertification and Why it is Necessary

Precertification of services is a vital program feature—it involves a review to determine the medical appropriateness/necessity of certain procedures. Experience and medical research has shown that precertification is important to determine that the procedure to be performed, or the service to be provided, is appropriate. In some instances, an alternate treatment may be available that is equally effective. Precertification also helps determine the most appropriate setting for certain services because doctors can provide services in many settings, such as the outpatient department of a hospital, the doctor’s office or on an inpatient basis. The precertification process is designed so that you can get health care in an appropriate setting.

Precertification is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the precertification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions and other specific terms of the health benefits plan that apply to the coverage request.

If you request precertification and have been notified in writing that the admission/service will not be paid or the service is not covered because it is not considered medically necessary or appropriate, and you decide to continue treatment that has not been approved, you will be asked to:

- Acknowledge this in writing
- Request to have services provided
- State your willingness to assume financial liability

As a PPO Program member, you can appeal decisions made about services received and services requested. Should you choose to do so, you can follow the appeals process outlined in your benefit booklet.

How to Precertify Services

Call 1-800-ASK-BLUE (1-800-275-2583) to initiate precertification. Refer to your benefit booklet for the list applicable to your PPO Program plan.

For mental health and substance abuse treatment services, contact the behavioral health management company that administers mental and substance abuse benefits at the telephone number on your ID card.

What Happens if I Don’t Call to Precertify Services When Required?

It is important for you to follow precertification requirements to get the most from your PPO Program plan. Failure to precertify services when required will result in a reduction in benefits and greater out-of-pocket costs.

Any questions? Call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at www.ibx.com.

2.11
Member Rights and Responsibilities

We respect your rights and encourage you to exercise your responsibilities. The following are your rights and responsibilities as a member:

Member Rights

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

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

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

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

• Upon exhaustion of the internal member appeal process, you may have the right to file for external review by state regulatory authorities or an independent review organization. Your external appeal rights vary and will depend on whether: 1) you are enrolled in an HMO, POS, or PPO; 2) your health plan is fully-insured or self-insured; and 3) your appeal is about a medical necessity issue or an administrative issue. For more information, see the appeal instructions in the decision letter for your final level of internal member appeal review.

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

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

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

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

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

• You have the right to make recommendations regarding your health plan’s policy on member rights and responsibilities. To make any recommendations, please call Customer Service 1-800-ASK-BLUE (1-800-275-2583).
**Member Responsibilities**

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

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

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

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

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

**Alpha Prefix**
Three characters preceding your ID number on your ID card. The three characters are required for routing claims. It identifies your Blue Cross®/Blue Shield® Plan or national account.

**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 Independence Blue Cross.

**bcbs.com**
The Blue Cross and Blue Shield Association’s web site, which contains useful information about BlueCard programs and providers.

**BlueCard Access®**
A toll-free number you can use to find BlueCard providers in another Blue Cross®/Blue Shield® Plan area. The telephone number is **1-800-810-BLUE (1-800-810-2583)**.

**BlueCard® Doctor and Hospital Finder Web Site (www.bcbs.com)**
A web site you can use to find BlueCard providers in another Blue Cross®/Blue Shield® Plan area.

**BlueCard® PPO**
A national program that offers members traveling or living outside of their Blue Cross®/Blue Shield® Plan area the in-network level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

**BlueCard® PPO Network**
A network of doctors, hospitals and other health care providers that PPO members may use to obtain the highest level of PPO benefits when they travel or live outside their Blue Cross®/Blue Shield® Plan area.

**BlueCard® PPO Provider**
A doctor, hospital or other health care provider enrolled in a network of designated PPO providers.

**BlueCard Worldwide®**
A program that allows Blue Cross® and Blue Shield® members traveling or living abroad to receive inpatient, outpatient and professional services from participating health care providers worldwide.

**Coinurance**
A cost-sharing requirement in which the covered person assumes a percentage of the covered expense for covered services (e.g., 20 or 30 percent).

**Complaint**
Any expression of dissatisfaction, verbal or written, by a member.
**Copayment**
A type of cost-sharing in which the covered person pays a flat dollar amount each time a covered service is provided—such as $10 or $15 per office visit.

**Deductible**
The amount that must be incurred by a covered person before the insurer will assume liability for its share of the remaining covered expense for covered services.

**Emergency Services**
Health care or psychiatric services you receive if you become suddenly sick or injured with acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious medical consequences or place one's health in serious jeopardy.

**Non-Preferred Provider**
A hospital, doctor or other health care provider that is not a member of the Personal Choice® Network and does not participate in another Blue Cross®/Blue Shield® Plan's BlueCard® PPO network.

**Out-of-Area Services**
Services provided outside the Personal Choice Network service area.

**Personal Choice® Network Service Area**
The geographical area within which Independence Blue Cross (IBC) contracts to provide services covered under Personal Choice. The service area includes Bucks, Chester, Delaware, Montgomery and Philadelphia and adjacent counties (Bucks, Chester, Delaware, Montgomery and Philadelphia and adjacent counties (Berks, Lancaster, Lehigh and Northampton in Pennsylvania; Burlington, Camden, Gloucester, Hunterdon, Mercer, Salem and Warren in New Jersey; New Castle County in Delaware; and Cecil County in Maryland). When you choose network providers you will generally receive the highest level of benefits with the lowest out-of-pocket expense.

**Preauthorization/Precertification**
Prior assessment of the medical necessity or appropriateness of proposed services, such as a patient's admission to a hospital. Typically, the review involves verifying the patient's eligibility for services, opening the patient's claim record and, with respect to an inpatient admission, establishing an expected diagnosis and length of stay.

**Preferred Provider**
A hospital, doctor or other health care provider that belongs to the Personal Choice® Network or who participates in another Blue Cross®/Blue Shield® Plan's BlueCard® PPO network. These providers are authorized to perform specific covered services at the in-network level of benefits.

**Provider**
Any individual that is licensed (such as a doctor, nurse or other health care provider) or facility that is licensed (such as a hospital) to provide medical care.

**Urgent Care**
Covered services provided to treat an unexpected illness or injury that is not an emergency.
A Word About Privacy

At Independence Blue Cross, protecting your privacy is very important to us. That is why we have taken numerous steps to see that our members’ protected health information (PHI) is kept confidential. Protected health information (PHI) is individually identifiable health information about you. This information may be in oral, written or electronic form. Independence Blue Cross may obtain or create your PHI while conducting our business of providing you with health care benefits.

Independence Blue Cross has implemented extensive policies and procedures regarding the collection, use and release or disclosure of PHI by and within our organization. We continually review our policies and monitor our business processes to make sure that your information is protected while assuring that the information is available as needed for the provision of health care services. For example, our procedures include steps to assist us in verifying the identity of someone calling to request PHI, procedures to limit who on our staff has access to your PHI, and to share only the minimum amount of information when PHI must be disclosed. We also protect any PHI transmitted electronically outside our organization by using only secure networks or by using encryption technology if the information is sent by e-mail.

We do not use or share your PHI without your permission unless the law allows us to do so. Before using or disclosing your PHI for other purposes, we’ll obtain your written permission, also called an authorization. You may also direct us to share your PHI with someone you chose by giving us your written authorization. However, this authorization must include certain specific information in order to be valid. You may print a copy of our “Authorization to Release Information” form from our website, www.ibx.com, or request a copy by calling our Privacy Office at (215) 241-4735.

We are permitted to use or disclose your PHI for our payment and health care operations. Examples of these activities include paying claims for services you’ve received, coordinating the delivery of health care services, and monitoring the performance of our network providers to improve health care outcomes. We may also share your PHI in certain other circumstances, such as disclosures to health care oversight agencies for legally authorized health oversight activities like audits and investigations, or when we are required to do so by law. We may also share certain information with the sponsor of your group health plan so that they may perform their plan administration functions.

The laws that protect your privacy also give you certain rights related to your PHI. For example, you may request a copy of your PHI that we have in our “Designated Record Set”. Please remember that Independence Blue Cross does not typically have copies of your medical records. Your health care provider should be contacted for copies of your medical records.

Please review our Notice of Privacy Practices for more detailed information about your privacy rights and how we may use and share your PHI. You may view or print a copy of our Notice from our website, www.ibx.com by clicking on “Privacy Policies”. Or you may call our Privacy Office at (215) 241-4735 to request that a copy of the Notice be mailed to you.

Any questions? Call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583) or visit our website at www.ibx.com.
Important Telephone Numbers

For Benefit and Claims Questions, call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583).

To find a Personal Choice Network Provider, call the Health Resource Center at 1-800-ASK-BLUE (1-800-275-2583) or Visit the Independence Blue Cross web site at www.ibx.com

To find a BlueCard® PPO Provider, call BlueCard Access at 1-800-810-BLUE (1-800-810-2583) or Visit the BlueCard Doctor and Hospital Finder web site at www.bcbs.com
Your Benefits
Your Benefits

SCHEDULE OF BENEFITS.....................................................3.1-2
BENEFIT RIDER..........................................................3.1-15
BENEFIT RIDER..........................................................3.1-16
BENEFIT BOOKLET.........................................................3.2-1
SCHEDULE OF BENEFITS

Subject to the exclusions, conditions and limitations of this Plan, a Covered Person is entitled to benefits for the Covered Services described in this Schedule of Benefits 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 Benefits are not always calculated on actual charges. For an explanation on how Coinsurance is calculated, see the Covered Expense definition in the Defined Terms section.

Covered Services may be provided “In-Network” by a Preferred Provider or “Out-of-Network” by a Non-Preferred Provider. However, the Covered Person will maximize the benefits available when Covered Services are provided In-Network by a Provider that belongs to the Personal Choice Network (a Preferred Provider) and has a contract with the Carrier to provide services and supplies to the Covered Person. The Your Personal Choice Network Plan section provides more detail regarding Preferred and Non-Preferred Providers and the Personal Choice Network.

Some Covered Services must be Precertified before the Covered Person receives the services. Precertification of services is a vital program feature that reviews Medical Appropriateness/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 Your Personal Choice Network Plan and the Managed Care sections. Covered Services that require Precertification, and any Penalty for failure to obtain a Precertification, are specified on the Schedule of Benefits.

**BENEFIT PERIOD**  
Contract Year

**PROGRAM DEDUCTIBLE**  
*(Covered Person’s Responsibility)*

Covered Person's Deductible

- **Preferred Care**  
  None

- **Non-Preferred Care**  
  $500 per Covered Person per Benefit Period for Non-Preferred Covered Services. This Deductible applies to all Non-Preferred Covered Services except as otherwise specified in the Schedule of Benefits.

Family Deductible

- **Preferred Care**  
  None

- **Non-Preferred Care**  
  The family Deductible amount is equal to 3 times the individual Deductible. 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 individual family member once that covered individual has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined.

Deductible Carryover

Expenses Incurred for Covered Expenses in the last 3 months of a Benefit Period which were applied to that Benefit Period’s Deductible will be applied to the Deductible of the next Benefit Period.
## COINSURANCE
*(Covered Person’s Responsibility)*

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Care</strong></td>
<td>0% for Covered Services, except as otherwise specified in the <em>Schedule of Benefits</em>.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td>30% for Covered Services, except as otherwise specified in the <em>Schedule of Benefits</em>. For Treatment of Alcohol and Drug Abuse and Dependency services, in the first instance or course of treatment, no Deductible or Coinsurance shall be less favorable than those applied to similar classes or categories of treatment for physical illness.</td>
<td></td>
</tr>
</tbody>
</table>

## OUT-OF-POCKET LIMIT

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Care</strong></td>
<td>None.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td>When a Covered Person Incurs $3,000 of Coinsurance expense in one Benefit Period for Non-Preferred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. After 3 times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount. The dollar amounts specified shall not include any expense Incurred for Mental Health / Psychiatric Care services, any Deductible, Penalty, or Copayment amount.</td>
<td></td>
</tr>
</tbody>
</table>

## LIFETIME MAXIMUM

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred Care</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Preferred Care</strong></td>
<td>$1,000,000 per lifetime per Covered Person for Non-Preferred Covered Services.</td>
<td></td>
</tr>
</tbody>
</table>

## REINSTATEMENT

Amounts applied to a Covered Person’s Lifetime Maximum are not restorable.
<table>
<thead>
<tr>
<th>PRIMARY AND PREVENTIVE CARE</th>
<th>If the Covered Person uses a Preferred Provider, the Plan will pay:</th>
<th>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OFFICE VISITS</td>
<td>100%, after a Copayment of $15 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td>PEDIATRIC PREVENTIVE CARE</td>
<td>100%, after a Copayment of $15 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td>PEDIATRIC IMMUNIZATIONS</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>ADULT PREVENTIVE CARE</td>
<td>100%, after a Copayment of $15 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td>ROUTINE GYNECOLOGICAL EXAMINATION, PAP SMEAR</td>
<td>100%, after a Copayment of $15 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>MAMMOGRAMS</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
</tr>
<tr>
<td>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Maximum of six (6) visits per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Deductible does not apply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Inpatient Benefits

<table>
<thead>
<tr>
<th></th>
<th>If the Covered Person uses a Preferred Provider, the Plan will pay:</th>
<th>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td>100%, after a Copayment of $100 per day, up to a maximum copay of 5 days.</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Benefit Period Maximum: 365 Preferred Inpatient days.</td>
<td>Benefit Period Maximum: 70 Non-Preferred Inpatient days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>This maximum is part of, not separate from, Preferred days maximum.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>Medical Care</strong></td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Skilled Nursing Care Facility</strong></td>
<td>100%, after a Copayment of $50 per day, up to a maximum copay of 5 days</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Maximum of 120 Preferred/Non-Preferred Inpatient days per Benefit Period.</td>
<td>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td></td>
<td>Precertification required for all Skilled Nursing Care Facility Inpatient admissions.</td>
<td></td>
</tr>
</tbody>
</table>
## INPATIENT/OUTPATIENT BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>If the Covered Person uses a Preferred Provider, the Plan will pay:</th>
<th>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Respite Care: Maximum of 7 days every 6 months.</td>
<td>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
<td></td>
</tr>
</tbody>
</table>

## MATERNITY OB-GYN/FAMILY SERVICES

**Maternity/Obstetrical Care**

- **Professional Service**: 100%, after a single Copayment of $15 [70%]
- **Facility Service**: 100%, after a Copayment of $100 per day, up to a maximum copay of 5 days [70%]
- **Newborn Care**: 100% [70%]
- **Artificial Insemination**: 100%, after a Copayment of $15 per visit [70%]
### INPATIENT/OUTPATIENT BENEFITS

**Continued**

<table>
<thead>
<tr>
<th></th>
<th>If the Covered Person uses a Preferred Provider, the Plan will pay:</th>
<th>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MENTAL HEALTH/PSYCHIATRIC CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Treatment</td>
<td>100%, after a Copayment of $100 per day, up to a maximum copay of 5 days.</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Benefit Period Maximum: 30 Preferred Inpatient days.</td>
<td>Benefit Period Maximum: 20 Non-Preferred Inpatient days. This maximum is part of, not separate from, Preferred days maximum.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
</tr>
</tbody>
</table>

Mental Health/Psychiatric Care Inpatient days limits are part of, not separate from, the Inpatient Hospital Services days limit.

|                      |                                                                      |                                                                      |
| Outpatient Treatment | 100%, after a Copayment of $20 per visit.                           | 50%                                                                  |
|                      |                                                                      | This maximum is part of, not separate from, Preferred visit maximum. |

30 Mental Health/Psychiatric Care Inpatient days may be exchanged for additional Partial Hospitalization services or Mental Health/Psychiatric Care Outpatient visits. Each Inpatient day may be exchanged for 4 Outpatient visits or 2 Partial Hospitalization visits.

|                      |                                                                      |                                                                      |
| Inpatient Treatment for Serious Mental Illness | 100%, after a Copayment of $100 per day, up to a maximum copay of 5 days. | 70%                                                                  |
|                      | Benefit Period Maximum: 30 Preferred Inpatient days.                 | Benefit Period Maximum: 30 Non-Preferred Inpatient days. This maximum is part of, not separate from, Preferred days maximum. |
|                      |                                                                      | Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable. |
### INPATIENT/OUTPATIENT BENEFITS

**Continued**

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Treatment for Serious Mental Illness</td>
<td>100%, after a Copayment of $20 per visit.</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 60 Preferred Outpatient visits.</td>
<td>Benefit Period Maximum: 60 Non-Preferred Outpatient visits.</td>
<td>This maximum is part of, not separate from, Preferred visit maximum.</td>
</tr>
</tbody>
</table>

Each available Inpatient Treatment for Serious Mental Illness day may be exchanged for 2 additional Partial Hospitalization days/Outpatient Treatment sessions.

### SURGICAL SERVICES

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Facility Charges</td>
<td>100%, after a Copayment of $100 per date of service.</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient Professional Charge</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient Anesthesia</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>100%, after a Copayment of $25 per opinion.</td>
<td>70%</td>
</tr>
</tbody>
</table>

Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable for certain Surgical Services.

If more than 1 surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.
### INPATIENT/OUTPATIENT BENEFITS  
**Continued**

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Non-Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSPLANT SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Facility Charges</td>
<td>100%, after a Copayment of $100 per day, up to a maximum copay of 5 days.</td>
<td>70%</td>
</tr>
<tr>
<td>Outpatient Facility Charges</td>
<td>100%, after a Copayment of $100 per date of service.</td>
<td>70%</td>
</tr>
<tr>
<td><strong>TREATMENT OF ALCOHOL OR DRUG ABUSE AND DEPENDENCY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification and Rehabilitation</td>
<td>100%, after a Copayment of $100 per day, up to a maximum copay of 5 days.</td>
<td>70%</td>
</tr>
<tr>
<td>7 days per admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum of 4 confinements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital and Non-Hospital Residential Care</td>
<td>100%, after a Copayment of $100 per day, up to a maximum copay of 5 days.</td>
<td>70%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred/Non-Preferred Inpatient days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum: 90 Preferred/Non-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Inpatient days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient treatment days limits are part of, not separate from, the Hospital Inpatient days limits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Treatment</td>
<td>100%, after a Copayment of $20 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred/Non-Preferred Outpatient visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum: 120 Preferred/Non-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Outpatient visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Outpatient Treatment of Alcohol or Drug Abuse or Dependency days may be exchanged on a 2-to1 basis for 15 additional days of Non-Hospital Residential Care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT BENEFITS</td>
<td>If the Covered Person uses a <strong>Preferred Provider</strong>, the Plan will pay:</td>
<td>If the Covered Person uses a <strong>Non-Preferred Provider</strong>, the Plan will pay:</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>AMBULANCE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Non-Emergency services</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to Precertify Non-Preferred Non-Emergency Ambulance services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>DAY REHABILITATION PROGRAM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Period Maximum: Thirty (30) visits</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td><strong>DIABETIC EDUCATION PROGRAM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits for Non-Preferred services are not available.</td>
</tr>
<tr>
<td><strong>DIABETIC EQUIPMENT AND SUPPLIES</strong></td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefit Period Maximum: $2,500.00 of Non-Preferred Diabetic Equipment and Supplies</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Diagnostic/Radiology Services</td>
<td>100%, after a Copayment of $20 per date of service.</td>
<td>70%</td>
</tr>
<tr>
<td>Non-Routine Diagnostic/Radiology Services (including MRI/MRA, CT scans, PET scans)</td>
<td>100%, after a Copayment of $40 per date of service.</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure to Precertify certain Non-Preferred Non-Routine Diagnostic / Radiology services will result in a 20% reduction in benefits payable.</td>
</tr>
<tr>
<td>Laboratory and Pathology Tests</td>
<td>100%</td>
<td>70%</td>
</tr>
</tbody>
</table>
## OUTPATIENT BENEFITS

**Continued**

<table>
<thead>
<tr>
<th></th>
<th>If the Covered Person uses a Preferred Provider, the Plan will pay:</th>
<th>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT</strong></td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Benefit Period Maximum:</strong></td>
<td>$2,500.00 of Non-Preferred Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td><strong>Precertification of Non-Preferred supplies is required for items with a billed amount that exceeds $500 (includes replacements and repairs).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EMERGENCY CARE SERVICES</strong></td>
<td>100%, after a Copayment of $50. (Not waived if admitted.)</td>
<td>100%, after a Copayment of $50. (Not waived if admitted.)</td>
</tr>
<tr>
<td><strong>HOME HEALTH CARE</strong></td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INJECTABLE MEDICATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biotech/Specialty Injectables</td>
<td>100%, after a Copayment of $50 per injection.</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Injectables</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>INSULIN AND ORAL AGENTS</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

If this Plan does not provide coverage for prescription drugs, insulin and oral agents are covered less the applicable Copayment per prescription order:

Generic Copayment - $10  
Brand Copayment - $15
<table>
<thead>
<tr>
<th><strong>OUTPATIENT BENEFITS</strong></th>
<th><strong>If the Covered Person uses a Preferred Provider, the Plan will pay:</strong></th>
<th><strong>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL FOODS AND NUTRITIONAL FORMULAS</strong></td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>NON-SURGICAL DENTAL SERVICES</strong> (Dental Services as a result of Accidental Injury)</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>ORTHOTICS</strong></td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Precertification of Non-Preferred supplies is required for items with a billed amount that exceeds $500 (including replacement and repairs). Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
<td></td>
</tr>
<tr>
<td><strong>PODIATRIC CARE</strong></td>
<td>100%, after a Copayment of $25 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td><strong>PRIVATE DUTY NURSING SERVICES</strong></td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 360 Preferred/Non-Preferred hours</td>
<td>Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
<td></td>
</tr>
<tr>
<td><strong>PROSTHETIC DEVICES</strong></td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Precertification of Non-Preferred supplies is required for items with a billed amount that exceeds $500 (including replacement and repairs). Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable.</td>
<td></td>
</tr>
<tr>
<td>OUTPATIENT BENEFITS</td>
<td>If the Covered Person uses a Preferred Provider, the Plan will pay:</td>
<td>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
</tbody>
</table>

**SPECIALIST OFFICE VISITS**

100%, after a Copayment of $25 per visit.  
70%

**SPINAL MANIPULATION SERVICES**

Benefit Period Maximum: 20 Preferred/Non-Preferred visits

100%, after a Copayment of $20 per visit.  
70%

**THERAPY SERVICES**

**Cardiac Rehabilitation Therapy**

Benefit Period Maximum: 36 Preferred/Non-Preferred sessions

100%, after a Copayment of $20 per visit.  
70%

**Chemotherapy**

100%  
70%

**Dialysis**

100%  
70%

**Infusion Therapy**

100%  
70%

Failure to Precertify Non-Preferred services will result in a 20% reduction in benefits payable for Infusion Therapy.

**Orthoptic/Pleoptic Therapy**

Lifetime Maximum: 8 Preferred Non-Preferred sessions

100%, after a Copayment of $20 per visit.  
70%

**Pulmonary Rehabilitation Therapy**

Benefit Period Maximum: 36 Preferred/Non-Preferred sessions

100%, after a Copayment of $20 per visit.  
70%
<table>
<thead>
<tr>
<th>OUTPATIENT BENEFITS</th>
<th>If the Covered Person uses a Preferred Provider, the Plan will pay:</th>
<th>If the Covered Person uses a Non-Preferred Provider, the Plan will pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy/Occupational Therapy</td>
<td>100%, after a Copayment of $20 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 30 Preferred/Non-Preferred sessions of Physical Therapy/Occupational Therapy combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Period Maximum amounts that apply to Physical Therapy do not apply to the treatment of lymphedema related to mastectomy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>100%, after a Copayment of $20 per visit.</td>
<td>70%</td>
</tr>
<tr>
<td>Benefit Period Maximum: 20 Preferred/Non-Preferred sessions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
QCC INSURANCE COMPANY

Notice of Change

This Notice of Change is issued to form part of the QCC Insurance Company’s Vision Care Booklet/Certificate (Form No. 5046-BC)

Effective as of the dates shown below, this notice changes the language that describes the provisions, conditions or other terms of the Vision Care Program Booklet/Certificate as follows:

I. Effective February 22, 2006, the following is added under the Who Is Covered section. It expands the limiting age provisions for coverage of a full-time Dependent child who is a full-time student enrolled in an Accredited Educational Institution:

A full-time student who is eligible for coverage under the coverage who is (1) 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 (2) 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 Carrier approved by the Department of Military & Veterans Affairs (DMVA): (1) notifying the Carrier that the Dependent has been placed on active duty; (2) notifying the Carrier that the Dependent is no longer on active duty; (3) 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.

II. Effective January 1, 2007, the following new subsection is added to the General Information section:

Special Circumstances

In the event that Special Circumstances result in a severe impact to the availability of providers and services, or to the procedures required for obtaining benefits for Covered Services under this coverage (e.g., use of Participating Providers), or to the administration of this benefit program by the Carrier, the Carrier may on a selective basis, waive certain procedural requirements of the coverage. 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 Carrier 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 Carrier nor 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 Carrier and appropriate regulatory authority, are extraordinary circumstances not within the control of the Carrier, including but not limited to: (a) major disaster; (b) epidemic; (c) pandemic; (d) the complete or partial destruction of facilities; (e) riot; or (f) civil insurrection.

All other terms of the Booklet/Certificate remain in effect.

R. Scott Post
Vice President
Marketing Administration

5046.VIS.BC.r4
AMENDMENT TO YOUR PERSONAL CHOICE/PPO AGREEMENT

QCC INSURANCE COMPANY

This Notice of Change is issued to form part of your Booklet/Certificate that describes QCC Insurance Company's Personal Choice/PPO Health Benefits Program, a Preferred Provider Organization Health Care Program (Form No. 16750.BC).

This Notice changes the language that describes the provisions, conditions or other terms of the Booklet/Certificate as detailed below.

I. Effective April 21, 2008:

The definition of Medically Appropriate/Medically Necessary (or Medical Appropriateness/Medical Necessity in the Defined Terms section is replaced with the following:

MEDICALLY NECESSARY (or MEDICAL NECESSITY) - 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, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature 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.

All references to Medically Appropriate or Medical Appropriateness in the Booklet/Certificate are removed or replaced with Medically Necessary or Medical Necessity.

II. Effective January 1, 2009:

A. The Defined Terms section is modified:

1. The definition of Partial Hospitalization is replaced:

PARTIAL HOSPITALIZATION PROGRAM – medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment (Intensive Outpatient Program or Outpatient office visit) but who does not require Inpatient confinement.

2. The definition of Intensive Outpatient Program is added:

INTENSIVE OUTPATIENT PROGRAM – planned, structured services comprised of coordinated and integrated multidisciplinary services designed to treat a patient often in crisis who suffers from Mental Illness, Serious Mental Illness or Alcohol or Drug Abuse/Dependency. Intensive Outpatient Program treatment is an
alternative to Inpatient Hospital treatment or Partial Hospitalization Program treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until he is able to transition to less intensive outpatient treatment, as required.

B. The Description of Benefits section is modified:

1. The “Mental Health/Psychiatric Care” subsection is amended:

   a. The second paragraph under the heading “Mental Health/Psychiatric Care” in the “Inpatient/Outpatient Benefits” subsection is replaced; new language is shown in bold:

   Pre-authorization information must be submitted by the Provider to the Carrier for review and evaluation so a Plan of Treatment may be pre-certified for the Covered Person. Precertification must be obtained for all Inpatient treatment, Intensive Outpatient Program and Partial Hospitalization Program services, other than Emergency Care, in order to assure the Medical Necessity of the proposed treatment based on the nature and severity of the Covered Person’s condition. A personal assessment by a Preferred Professional Provider will be provided by the Carrier at no cost to the Covered Person to accommodate the Precertification process. Emergency Care is exempt from the requirements for Precertification and will be considered Preferred Care. However, Emergency admissions or services must be reviewed and authorized within two (2) business days of the admission or services, or as soon as possible as determined by the Carrier.

   b. The first paragraph under the heading “Outpatient Treatment” is replaced; new language is shown in bold:

   Benefits are provided, subject to the Benefit Period limitations shown in the Schedule of Benefits, for Outpatient treatment of Mental Illness and Serious Mental Illness. Outpatient mental health/psychiatric services shall be covered for the full number of Outpatient session visits or an equivalent number of Intensive Outpatient Program or Partial Hospitalization Program visits per Benefit Period. For treatment of Mental Illness the Covered Person may trade off: (a) on a one (1) for two (2) basis, Inpatient days for additional separate Intensive Outpatient Program or Partial Hospitalization Program services; or (b) on a one (1) for four (4) basis, Inpatient days for additional Outpatient visits. See the Schedule of Benefits for limits on the number of Inpatient days that may be exchanged in any Benefit Period. For treatment of Serious Mental Illness, the Covered Person may trade on a one (2) for two (2) basis, Inpatient days for additional Intensive Outpatient Program or Partial Hospitalization Program/Outpatient session visits. For maximum benefits, treatment must be performed by a Preferred Professional Provider/Preferred Facility Provider. All Intensive Outpatient Program and Partial Hospitalization Program services must be pre-certified by the Carrier.
2. The “Pediatric Preventive Care” subsection is amended:

The first paragraph entitled “Physical Examination, Routine History, Routine Diagnostic Tests” is replaced with the following; new language is in bold:

1. Physical Examination, Routine History, Routine Diagnostic Tests. Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e., 2-3 months), the dash indicates that coverage is available for one service from two (2) months through three (3) months of age.

Twenty-six (26) examinations up to age seventeen (17) – according to each of the following age groupings:

- Eleven (11) exams between the ages of 0-30 months within the following age ranges:

<table>
<thead>
<tr>
<th>3-5 days</th>
<th>6-8 months</th>
<th>2-3 months</th>
<th>4-5 months</th>
<th>9-11 months</th>
<th>12-14 months</th>
<th>15-17 months</th>
<th>24-29 months</th>
<th>30 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 month</td>
<td>18-23 months</td>
<td>1-2 months</td>
<td>2-3 months</td>
<td>9-11 months</td>
<td>12-14 months</td>
<td>15-17 months</td>
<td>24-29 months</td>
<td>30 months</td>
</tr>
</tbody>
</table>

- One (1) exam every calendar year between three (3) and seventeen (17) years of age.

3. The “Adult Preventive Care” subsection is amended:

a. The first paragraph entitled “Physical Examination, Routine History” is replaced with the following:

Physical Examination, Routine History. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons eighteen (18) years of age or older in accordance with the following schedule:

- One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
- One (1) examination every two (2) calendar years between twenty-two (22) and thirty-nine (39) years of age
- One (1) examination every calendar year, beginning at the age of forty (40)

b. The paragraph entitled “Complete Blood Count (CBC)” is replaced with the following:

Complete Blood Count (CBC). This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.

- One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
• One (1) examination **every two (2) calendar years** between twenty-two (22) and thirty-nine (39) years of age

4. A new paragraph is added under the list of “Biotech/Specialty Injectables” in the subsection entitled “Injectable Medications”.

**THIS LIST IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.**

C. The *Managed Care* section is modified:

1. The first paragraph of the introduction to “Other Precertification Requirements” subsection is replaced; new language is shown in bold:

   Precertification is required by the Carrier in advance for Home Health Care, **Inpatient** Hospice Care, certain surgical and diagnostic procedures. **Inpatient** treatment and **Intensive Outpatient Program and Partial Hospitalization Program services for Mental Health/Psychiatric Care and Serious Mental Illness and** Inpatient and Outpatient treatment (including Partial Hospitalization services) of Alcohol and Drug Abuse. A list of Precertification requirements is shown in the “Services Requiring Precertification” subsection of this *Managed Care* section. When a Covered Person plans to receive any of these listed procedures, the Carrier will review the Medical Necessity of the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

2. The “Services Requiring Precertification” is amended:

   a. The list of services under the heading “Outpatient Services” is replaced:

   2. **OUTPATIENT SERVICES**

   a. Alcohol and Drug Abuse and Dependency (including Partial Hospitalization services)
   b. Ambulance Services – non-Emergency
   c. Birth Center (notification only)
   d. Day Rehabilitation Program
   e. Dental Services as a Result of Accidental Injury
   f. Durable Medical Equipment (items over $500 billed amount, including repairs and replacements, and all rentals). This Precertification requirement does not apply to oxygen, diabetic supplies and unit dose medication for nebulizers.
   g. Home Health Care
   h. **Intensive Outpatient Program and Partial Hospitalization Program services for** Mental Health / Psychiatric Care, Serious Mental Illness
   i. Comprehensive Pain Management Programs (including epidural injections)
   j. Private Duty Nursing
   k. Orthotics and Prosthetics (items over $500 billed amount, including repairs and replacements). This Precertification requirement does not apply to ostomy supplies.
1. Sleep Studies

b. The item entitled “6. INFUSION THERAPY” is modified:

i. The following paragraph is added:

IMPORTANT: THE LIST OF INFUSION DRUGS LISTED BELOW IS SUBJECT TO PRECERTIFICATION. THIS LIST IS SUBJECT TO CHANGE AS NEW INFUSION DRUGS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON THE IDENTIFICATION CARD.

ii. The notice below the list of Infusion Drugs is modified to read as follows:

*Infusion drugs that are newly approved by the FDA during the effective term of the Group Contract are considered new and emerging technology and will be subject to Precertification.

c. The paragraph under the item entitled “7. BIOTECH / SPECIALTY INJECTABLE DRUGS (see list under “Biotech / Specialty Injectables” in Description of Benefits)” is modified:

IMPORTANT: THIS LIST OF BIOTECH / SPECIALTY MEDICATION PRECERTIFICATION REQUIREMENTS IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. TO OBTAIN THE CURRENT LIST, PLEASE LOG ON TO THE WEBSITE OR CALL THE PHONE NUMBER THAT IS LISTED ON YOUR IDENTIFICATION CARD.

D. The Schedule of Benefits is modified:

The “Outpatient Treatment” heading under the “Mental Health/Psychiatric Care”, and the “Outpatient Treatment for Serious Mental Illness Care” items in “Inpatient/Outpatient Benefits” are expanded to include the following:

“Precertification required for all Intensive Outpatient Program and Partial Hospitalization Program services.

III. Effective July 1, 2009:

The subsection entitled “Services That Require Precertification” in the Managed Care section is amended.

The list of Infusion Therapy drugs provided in an Outpatient Facility or in a Professional Provider’s Office is amended:

a. Respigam and Genasense are removed.
b. Rituximab and Eloxatin are added.
IV. Effective January 1, 2010:

A. The Defined Terms section is expanded to include the following definition:

**SELF-INJECTABLE PRESCRIPTION DRUG (SELF-INJECTABLE DRUG)** – A Prescription Drug that: (a) is introduced into a muscle or under the skin by means of a syringe and needle; (b) can be administered safely and effectively by the patient or caregiver outside of medical supervision, regardless of whether initial medical supervision and/or instruction is required; and (c) is administered by the patient or caregiver.

B. The category entitled “Injectable Medications” under the “Outpatient Benefits” subsection of the Description of Benefits section is amended:

1. The introductory paragraph is replaced:

   **Injectable Medications**

   Benefits will be provided for injectable medications required in the treatment of an injury or illness when administered by a Provider.

2. The list of Biotech/Specialty Injectable Drugs is replaced with the following:

   **Biotech/Specialty Injectables:**

   Antiretroviral Agents
   - Fuzeon
   Botulinum Toxin Agents
   - Botox, Myobloc
   Central Nervous System Agents
   - Vivitrol
   Endocrine/Metabolic Agents
   - Eligard, Faslodex, Lupron, Sandostatin, Thyrogen, Trelstar, Vantas, Viadur, Zoladex
   Hematopoietic Agents
   - Aranesp, Epogen, Leukine, Neulasta, Neumega, Neupogen, Procrit
   Hepatitis/Interferon Alpha Agents
   - Alferon N
   Hyalurionate Agents
   - Euflexxa, Hylalgan, Orthovisc, Supartz, Synvisc
   Immunological Modifiers
   - Amevive
   Intra-Ocular Agents
   - Lucentis, Macugen, Vitrasert
   Multiple Sclerosis Agents/Interferon Beta Agents
   - Avonex

3. Item #2 entitled “Standard Injectables” is replaced:

2. **Standard Injectables**

   a. Refers to all other injectable medications including, but not limited to, allergy injections and extractions and injectable medications
administered solely in a Physician’s office such as antibiotic and steroid injections;

b. Self-Injectable Drugs generally are not covered. For more information on Self-Injectable Prescription Drugs (Self-Injectable Drugs), please refer to the What Is Not Covered section and the description of Insulin and Oral Agents coverage in the Description of Benefits section.

C. The What Is Not Covered section is expanded to include a new exclusion:

For Self-Injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered Self-Injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to Self-Injectable Prescription Drugs that are:

(a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by a Prescription Drug Rider or Free-Standing Prescription Drug Contract issued to the Group by the Carrier; or

(b) required for treatment of an emergency condition that requires a Self-Injectable Drug.

All other terms of your Booklet/Certificate shall remain in effect.

R. Scott Post
Vice President
Marketing Administration
PERSONAL CHOICE HEALTH BENEFITS PLAN

A COMPREHENSIVE MAJOR MEDICAL GROUP BOOKLET-CERTIFICATE

By and Between

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

And

Villanova University
(Called "the Group")

The Carrier certifies that you (the enrolled Employee and your enrolled eligible Dependents, if any) are entitled to the benefits described in this booklet/certificate, subject to the eligibility and effective date requirements.

This booklet/certificate replaces any and all booklet/certificates previously issued to you under any group contracts issued by the Carrier providing the types of benefits described in this booklet/certificate.

The Contract is between the Carrier and the Contractholder. This booklet/certificate is a summary of the provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

ATTEST:

R. Scott Post
Vice President
Marketing Administration

Comprehensive Major Medical Coverage that utilizes a Preferred Provider Network to maximize benefits while offering covered persons the choice of selecting Non-Preferred Providers, except where specifically prohibited by the contract, subject to a reduction of benefits. This coverage utilizes extensive Precertification and utilization management procedures, which must be followed to maximize benefits and avoid penalties.
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This booklet/certificate has been prepared so that you (the enrolled Employee and your enrolled eligible Dependents, if any) may become acquainted with the Personal Choice Health Benefits Plan (this Plan) offered by your employer. Coverage under your employer’s Personal Choice Health Benefits Plan is available to those employees who are eligible for the Coverage and enrolled in it. The Personal Choice Health Benefits Plan described in this booklet/certificate is subject to the terms and conditions of the Group Contract issued by QCC Insurance Company (the Carrier).

Benefits will not be available for services to a greater extent or for a longer period than is Medically Necessary/Medically Appropriate, as determined by the Carrier. The amount of benefits for any Covered Service will not exceed the amount charged by the health care provider, and will not be greater than any maximum amount or limit described or referred to in this booklet/certificate.

See "Important Notices".

And, read this booklet/certificate carefully.
IMPORTANT NOTICES

REGARDING EXPERIMENTAL/INVESTIGATIVE TREATMENT:

The Carrier 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 Carrier acknowledges that situations exist when a Covered Person and his or her Physician agree to utilize Experimental/Investigative treatment. If a Covered Person receives Experimental/Investigative treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Carrier to determine whether a treatment is considered Experimental/Investigative. The term “Experimental/Investigative” is defined in the Defined Terms section.

REGARDING TREATMENT WHICH IS NOT MEDICALLY APPROPRIATE / MEDICALLY NECESSARY:

The Carrier only covers treatment which it determines Medically Appropriate/Medically Necessary. A Member/Contracting Provider accepts the Carrier’s decision and contractually is not permitted to bill the Covered Person for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary unless the Member/Contracting Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Carrier, and that the Covered Person will be financially responsible for such services. A Non-Member/Non-Contracting Provider, however, is not obligated to accept the Carrier’s determination and the Covered Person may not be reimbursed for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Member/Non-Contracting Provider. You can avoid these charges simply by choosing a Member/Contracting Provider for your care. The term “Medically Appropriate/Medically Necessary” is defined in the Defined Terms section.

REGARDING TREATMENT FOR COSMETIC PURPOSES:

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

REGARDING COVERAGE FOR EMERGING TECHNOLOGY:

While the Carrier 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 Carrier 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 Covered Person, the Carrier researches all scientific information available from these expert sources. Following this analysis, the Carrier 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 Covered Person or his or her Provider should contact the Carrier to determine whether a proposed treatment is considered “emerging technology”.

3.2-2
Form No. 16750-BC  1.08
REGARDING USE OF NON-PREFERRED PROVIDERS

To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the Personal Choice Network or in the Blue Card PPO Program. While Personal Choice has an extensive network, it may not contain every provider that you need. You may obtain Covered Services from Participating Professional Providers or Member Facility Providers (Participating Providers) who are not part of the Personal Choice Network but have agreed to accept contracted rates as payment in full and will not balance bill you. However, you will be subject to Non-Preferred “Out-of-Network” Coinsurance and Deductibles.

In addition, your Personal Choice program allows you to obtain Covered Services from Non-Preferred, Non-Participating Providers. If you use a Non-Preferred, Non-Participating Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance and the balance of the provider’s bill. This is true whether you use a Non-Preferred, Non-Participating Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a provider.

The Plan may approve Covered Services provided by a Non-Preferred Provider subject to Preferred “In-Network” cost-sharing, if such cost-sharing is applicable to your program (Copayments, Coinsurance and Deductibles), if you have: (1) sought care from a Preferred Provider in the same specialty as the Non-Preferred Provider; (2) been advised by the Preferred Provider that there are no Preferred Providers that can provide the requested Covered Services; and (3) obtained authorization from the Plan prior to receiving care. The Plan reserves the right to make the final determination whether there is a Preferred Provider that can provide the Covered Services. If the Plan approves the use of a Non-Preferred, Non-Participating Provider, you will be not responsible for the difference between the provider’s billed charges and the Plan’s payment to the Provider. Applicable program terms including Medical Necessity/Appropriateness and precertification will apply.

REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of “Experimental/Investigative”, “cosmetic”, or “emerging technology”, the Covered Person, or his or her Provider, should contact the Carrier for a coverage determination. That way the Covered Person and the Provider will know in advance if the treatment will be covered by the Carrier.

In the event the treatment is not covered by the Carrier, the Covered Person 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 Carrier for coverage determinations, please see the Precertification and Prenotification requirements in the Managed Care section.
The terms below have the following meaning when describing the benefits within this booklet/certificate. They will be helpful to you (the Covered Person) in fully understanding your benefits.

**ACCESSIBILITY** – the extent to which a member of a Managed Care Organization can obtain from a Preferred Provider available Covered Services at the time they are needed. Accessibility to a Preferred Provider refers to both telephone access and ease of scheduling an appointment.

**ACCIDENTAL INJURY** - bodily injury which results from an accident directly and independently of all other causes.

**ACCREDITED EDUCATIONAL INSTITUTION** – a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) 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.

**ALCOHOL OR DRUG ABUSE AND DEPENDENCY** - any use of alcohol or other drugs which produce a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

**ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE** – Complementary and alternative medicine, as defined by the National Institute of Health’s National Center for Complementary and Alternative Medicine (NCCAM) is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g. homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions which include a variety of techniques designed to enhance the mind’s capacity to affect bodily function and symptoms (e.g. meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance); (c) biologically based therapies using natural substances such as herbs, foods, vitamins or nutritional supplements to prevent and treat illness, (e.g. diets, macrobiotics, megavitamin therapy); (d) manipulative and body-based methods (e.g. massage, equestrian/hippotherapy); and (e) energy therapies, involving the use of energy fields. The energy therapies are of two types: (1) Biofield therapies – intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in or through these fields. Examples include Qi Gong, Reiki, and therapeutic touch. (3) Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

**AMBULATORY SURGICAL FACILITY** - a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health Care, Inc., or by the Carrier and which:

A. Has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;

B. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

C. Does not provide Inpatient accommodotions; and

D. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.
ANSILLARY PROVIDER – an individual or entity that provides services, supplies or equipment (such as, but not limited to, Infusion Therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under this Plan.

ANESTHESIA - consists of the administration of regional anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

APPEAL – a request by a Covered Person, or the Covered Person’s representative or Provider, acting on the Covered Person’s behalf upon written consent, to change a previous decision made by the Carrier.

A. Administrative Appeal – an Appeal by or on behalf of a Covered Person 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 or Medical Appropriateness, but these are not the primary issues that affect the outcome of the Appeal.

B. Medical Necessity Appeal – a request for the Carrier to change its decision, based primarily on Medical Appropriateness/Medical Necessity, to deny or limit the provision of a Covered Service.

C. Expedited Appeal – a faster review of a Medical Necessity Appeal, conducted when the Carrier determines that a delay in decision making would seriously jeopardize the Covered Person’s life, health, or ability to regain maximum function.

APPLICANT AND EMPLOYEE/MEMBER - you, the Employee who applies for coverage under this Plan.

APPLICATION AND APPLICATION CARD - the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Carrier.

ATTENTION DEFICIT DISORDER – a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

BENEFIT PERIOD - the specified period of time as shown in the Schedule of Benefits during which charges for Covered Services must be Incurred in order to be eligible for payment by the Carrier. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

BIRTH CENTER - a Facility Provider approved by the Carrier which (a) is licensed as required in the state where it is situated, (b) is primarily organized and staffed to provide maternity care, and (c) is under the supervision of a Physician or a licensed certified nurse midwife.

CASE MANAGEMENT – Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person outcomes. Case Management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

CERTIFIED REGISTERED NURSE - a certified registered nurse anesthetist, certified registered nurse practitioner, certified enteroostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

COGNITIVE REHABILITATION THERAPY – Medically prescribed therapeutic treatment approach designed to improve cognitive functioning after acquired central nervous system insult (e.g. trauma, stroke, acute brain insult, and encephalopathy). Cognitive rehabilitation is an integrated multidisciplinary approach that consists of tasks designed to reinforce or re-establish previously learned patterns of behavior or to establish new compensatory mechanisms for impaired neurological systems. It consists of a variety of therapy modalities which mitigate or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. Cognitive rehabilitation is performed by a physician, neuropsychologist, psychologist as well as a physical, occupational or speech therapist using a team approach.
**COINSURANCE** – a type of cost-sharing in which the Covered Person assumes a percentage of the Covered Expense for Covered Services (such as 20 percent).

**COMPLAINT** – any expression of dissatisfaction, verbal or written, by a Covered Person.

**COPAYMENT** - a type of cost-sharing in which the Covered Person 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 Benefits.

**COVERED EXPENSE** - refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For services rendered by a Facility Provider, the term "Covered Expense" may not refer to the actual amount(s) paid by the Carrier to the Provider(s). Under the Carrier's contracts, the Carrier pays Facility Providers using bulk purchasing arrangements that permit it to pay less for services and enable it to offer the Personal Choice Discount to its Personal Choice customers. The amount the Carrier pays at the time of any given claim may be more and it may be less than the amount used to calculate the Covered Person's liability. Rather, “Covered Expense” means the following:

1. For services rendered by a Preferred Facility Provider, “Covered Expense“ means the Facility Provider’s charges for the Covered Services reduced by the Personal Choice Discount in effect at the time that the services are rendered.

2. For services rendered by a Non-Preferred Member Facility Provider that has a direct contractual arrangement with the Carrier, “Covered Expense” means the Facility Provider’s charges for the Covered Services reduced by the Plan-Wide Discount in effect at the time that the services are rendered.

3. For services rendered by Non-Preferred Facility Providers that have no contractual arrangement with the Carrier, “Covered Expense” means the lesser of the: (a) Facility Provider’s charges, (b) Medicare Allowable Payment, or (c) Reasonable and Customary Charge for the Covered Services.

B. For services rendered by a Professional Provider, “Covered Expense” means the following:

1. For a Preferred Professional Provider - the rate of reimbursement for Covered services the Professional Provider has agreed to accept as set forth by contract with the Personal Choice Network, or the charge, whichever is less;

2. For a Participating Professional Provider - the rate of reimbursement for Covered Services will be made in accordance with the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services;

3. For a Non-Preferred, Non-Participating Professional Provider – the amount as determined by the Carrier's lowest network fee schedule that the Carrier would have paid to a Preferred Professional Provider for the same service, or the charge, whichever is less;

C. For services rendered by Ancillary Providers, "Covered Expense" means the following:

1. For services rendered by a Preferred Provider, "Covered Expense" means the amount that the Carrier has negotiated with the Preferred Provider as total reimbursement for the Covered Services.

2. For services rendered by a Non-Preferred Provider, "Covered Expense" means the lesser of the: (a) Provider’s charges, (b) Medicare Allowable Payment, or (c) Reasonable and Customary charge for the Covered Services.

**COVERED PERSON** – an enrolled Employee or his eligible Dependents who have satisfied the specifications of the Eligibility Under This Plan section. A Covered Person does not mean any person who is eligible for Medicare except as specifically stated in this booklet/certificate.
**COVERED SERVICE** - a service or supply specified in this booklet/certificate for which benefits will be provided by the Carrier.

**CUSTODIAL CARE** - provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his 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, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

**DAY REHABILITATION PROGRAM** – is a level of Outpatient care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Plan and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Covered Person returns home each evening and for the entire weekend.

**DECISION SUPPORT** – Decision Support describes a variety of services that help Covered Persons make educated decisions about health care and support their ability to follow their Provider’s treatment plan. Some examples of Decision Support services include, but are not limited to, support for major treatment decisions and information about everyday health concerns.

**DEDUCTIBLE** - a specified amount of Covered Expenses for the Covered Services that is Incurred by the Covered Person before the Carrier will assume any liability.

**DETOXIFICATION** - the process by which an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a licensed Facility Provider, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drug, or alcohol and other drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

**DISEASE MANAGEMENT** – a population-based approach to identify Covered Persons 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 Covered Persons and Providers, matching interventions to Covered Persons with the greatest opportunity for improved clinical or functional outcomes. Disease Management programs may employ education, Provider feedback and support statistics, compliance monitoring and reporting, and/or preventive medicine approaches to assist Covered Persons with chronic disease(s). 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** - is equipment which meets the following criteria:

A. It is durable and can withstand repeated use;
B. It is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;
C. It generally is not useful to a person in the absence of an illness or injury; and
D. It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to: diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, hospital beds, traction equipment and wheelchairs.

**EFFECTIVE DATE** - according to the *Eligibility Under This Plan* section, the date on which coverage for a Covered Person begins under this Plan. All coverage begins at 12:01 a.m. on the date reflected on the records of the Carrier.
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:

A. Placing the Covered Person’s health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part.

EMERGENCY CARE – Covered Services and supplies provided by a Hospital or Facility Provider and/or Professional Provider to a Covered Person in or for an Emergency on an Outpatient basis in a Hospital Emergency Room or Outpatient Emergency Facility.

EMPLOYEE - an individual of the Group who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

ENTERAL NUTRITION – the provision of nutritional requirements into the alimentary tract.

EXPERIMENTAL/INVESTIGATIVE – a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing Phase I or Phase II Clinical Trials;

B. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials 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;

C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person’s particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person’s particular condition; or

E. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person’s particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., 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 the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia: The American Hospital Formulary Service Drug Information; or The United States Pharmacopeia Drug Information; recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigative.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigative if it meets all of the criteria listed below:

A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure 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.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure 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.

**FACILITY PROVIDER** - an institution or entity licensed, where required, to provide care. Such facilities include:

A. Ambulatory Surgical Facility  
B. Birth Center  
C. Free Standing Dialysis Facility  
D. Free Standing Ambulatory Care Facility  
E. Home Health Care Agency  
F. Hospice  
G. Hospital  
H. Non-Hospital Facility  
I. Psychiatric Hospital  
J. Rehabilitation Hospital  
K. Residential Treatment Facility  
L. Short Procedure Unit  
M. Skilled Nursing Facility

**FAMILY COVERAGE** - coverage purchased for the Employee and one or more of the Employee’s Dependents.

**FREE STANDING AMBULATORY CARE FACILITY** - a Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a Physician. This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

**FREE STANDING DIALYSIS FACILITY** - a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the Carrier, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

**GROUP** (or **ENROLLED GROUP**) - a group of Employees which has been accepted by the Carrier, 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 Carrier.

**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) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound to the ear, and (d) 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: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely-in-the-canal, and (e) implantable (can be partial or complete). A Hearing Aid is not a cochlear implant.

**HOME HEALTH CARE AGENCY** - a Facility Provider, approved by the Carrier, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient'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 (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency, and (2) appropriately licensed in the state where it is located.
**HOSPITAL** - 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 Carrier and which:

A. Is a duly licensed institution;

B. 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;

C. Has organized departments of medicine;

D. Provides 24-hour nursing service by or under the supervision of Registered Nurses;

E. Is not, other than incidentally, a: Skilled Nursing Facility; nursing home; 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.

**IDENTIFICATION CARD** - the currently effective card issued to the Covered Person by the Carrier which must be presented when a Covered Service is requested.


**INCURRED** - a charge shall be considered incurred on the date the Covered Person 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.

**INDEPENDENT REVIEW ORGANIZATION (IRO)** – an entity qualified by applicable licensure and/or accreditation standards to act as the independent decision maker on external Medical Necessity appeals requiring evaluation of issues related to Medical Appropriateness/Medical Necessity of a Covered Person's request for Covered Services. The Carrier arranges for the availability of IROs and assigns them to external Medical Necessity appeals. IROs are not corporate affiliates of the Carrier.

**INPATIENT ADMISSION (or INPATIENT)** – a Covered Person's actual entry into a Hospital, extended care facility or Facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Facility Provider and for whom a room and board charge is made; the Inpatient Admission shall continue until such time as the Covered Person is actually discharged from the facility.

**INPATIENT CARE FOR ALCOHOL OR DRUG ABUSE AND DEPENDENCY** - the provision of medical, nursing, counseling or therapeutic services, for Covered Persons suffering from Alcohol or Drug Abuse or dependency, twenty-four (24) hours a day in a Hospital or Non-Hospital Facility, according to individualized treatment plans.

**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.

**LIMITING AGE FOR DEPENDENTS** – the age at which a Dependent child shall be removed from the Employee’s coverage. The Limiting Age for covered, unmarried children is shown in the *Eligibility Under the Plan* section.

**MAINTENANCE** - continuation of care and management of the Covered Person when the maximum therapeutic value of a Medically Appropriate/Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Services for a condition ceases to be of therapeutic value and is no longer Medically Appropriate/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 (for Mental Health/Psychiatric Services) – a therapist who holds a Master’s Degree in an acceptable human services-related field of study and is licensed as a therapist at an independent practice level 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 Covered Person 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 Covered Persons for the Covered Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Carrier to the Providers.

A Maximum may also be expressed in number of days or number of services for a specified period of time.

A. Benefit Maximum - the greatest amount of a specific Covered Service that a Covered Person may receive.
B. Lifetime Maximum - the greatest amount of Covered Services that a Covered Person may receive in his lifetime.

MEDICAL CARE - services rendered by a Professional Provider within the scope of his license for the treatment of an illness or injury.

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

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS / MEDICAL NECESSITY) – an intervention will be covered if it is a Covered Service, not specifically excluded, and Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by the Carrier’s medical director or physician designee, it meets all of the following criteria:

A. **It is a “Health Intervention”.** A Health Intervention is defined as an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a “medical condition” or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

   A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. **It is the most appropriate supply or level of service, considering potential benefits and harms to the Covered Person.**

C. **It is known to be “effective” in improving “health outcomes”**

   Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a “new” or “existing” intervention.

   1. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered to be new if it is not yet in widespread use for (a) the medical condition, and (b) patient indications being considered.

   “Scientific Evidence” consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.
Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

2. Existing interventions: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion.

For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for determinations of Medical Appropriateness/Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered.

If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion.

Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

Existing interventions can meet the contractual definition of Medical Appropriateness/Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. It is cost effective for this condition compared to alternative interventions, including no intervention.

“Cost effective” does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this definition of Medical Appropriateness/Medical Necessity. An intervention is covered if: (a) it is a Covered Service; (b) it is not excluded from this Plan; and (c) it is Medically Appropriate/Medically Necessary.

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 – the payment amount, as determined by the Medicare program, for a Covered Service or supply.

MEMBER FACILITY PROVIDER - a Facility Provider that is not part of the Personal Choice Network but is approved by and has a contractual relationship with the Carrier for the provision of services to Covered Persons.

MENTAL ILLNESS – any of various conditions categorized as mental disorders by the most recent edition of the International Classification of Diseases (ICD), wherein mental treatment is provided by a qualified mental health Provider. For purposes of the Group Contract, conditions categorized as Mental Illness do not include those conditions listed under Serious Mental Illness because the benefit limits for Mental Illness and Serious Mental Illness are separate and not cumulative.

NON-HOSPITAL FACILITY - a Facility Provider, licensed by the Department of Health for the care or treatment of persons suffering from Alcohol or Drug Abuse or dependency, except for transitional living facilities. Non-Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities and Free Standing Ambulatory Care Facilities for Partial Hospitalization Programs.
**NON-HOSPITAL RESIDENTIAL TREATMENT** - the provision of medical, nursing, counseling, or therapeutic services to Covered Persons suffering from Alcohol or Drug Abuse or dependency in a residential environment, according to individualized treatment plans.

**NON-MEMBER FACILITY PROVIDER** - a Facility Provider that does not have a contractual relationship with the Carrier for the provision of services to Covered Persons.

**NON-PARTICIPATING PROFESSIONAL PROVIDER** - a Professional Provider who has not agreed to accept a rate of reimbursement determined by a contract with the Carrier for the provision of Covered Services to Covered Persons.

**NON-PREFERRED ANCILLARY PROVIDER** – an Ancillary Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

**NON-PREFERRED FACILITY PROVIDER** - a Facility Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

**NON-PREFERRED PROFESSIONAL PROVIDER** - a Professional Provider who is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

**NON-PREFERRED PROVIDER** - a Facility Provider, Professional Provider or Ancillary Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

**NUTRITIONAL FORMULA** – liquid nutritional products which are formulated to supplement or replace normal food products.

**OUT-OF-POCKET LIMIT** - a specified dollar amount of Coinsurance expense Incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include any Deductible, Penalties, Inpatient or Outpatient mental health/psychiatric care, or Copayment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the Schedule of Benefits.

**OUTPATIENT CARE (or OUTPATIENT)** - medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other Inpatient Facility.

**OUTPATIENT DIABETIC EDUCATION PROGRAM** – an Outpatient diabetic education program provided by a Preferred Provider which 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 provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient confinement.

**PARTICIPATING PROFESSIONAL PROVIDER** – a Professional Provider who has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

**PENALTY** – a type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified in the Schedule of Benefits and explained in detail in the Managed Care section.

**PERSONAL CHOICE DISCOUNT** – the percentage reduction from hospital billed charges for Covered Services that the Carrier passes on to its Personal Choice customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts with Preferred Facility Providers. The amount of the Personal Choice Discount may be changed prospectively from time to time. The Personal Choice Discount is on file with the Pennsylvania Insurance Department.

**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 Appropriate/Medically Necessary for the Covered Person’s diagnosis and condition.

PLAN-WIDE DISCOUNT – the percentage reduction from hospital charges for Covered Services that the Carrier passes on to its customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts. The amount of the discount may be changed prospectively from time to time. The amount of the discount is on file with the Pennsylvania Insurance Department.

PRECERTIFICATION (or PRECERTIFY) – prior assessment by the Carrier or designated agent that proposed services, such as hospitalization, are Medically Appropriate/Medically Necessary for a Covered Person and covered by this Plan. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan.

PREFERRED ANCILLARY PROVIDER – an Ancillary Provider that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for the provision of “in-network” Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER - a Facility Provider that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for the provision of “in-network” Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for “in-network” Covered Services rendered to a Covered Person.

PREFERRED PROVIDER – a Facility Provider, Professional Provider or Ancillary Provider that is a member of the Personal Choice Network, authorized to perform specific “in-network” Covered Services at the Preferred level of benefits.

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 Provider to coordinate care, and is not required to obtain referrals to see specialists.

PRENOTIFICATION (or PRENOTIFY) – the requirement that a Covered Person provide prior notice to the Carrier that proposed services, such as maternity care, are scheduled to be performed. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan.

PRIMARY CARE SERVICES – basic, routine medical care traditionally provided to individuals with common illnesses and injuries and chronic illnesses.

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".

PRIVATE DUTY NURSING - Medically Appropriate/Medically Necessary Outpatient continuous skilled nursing services provided to a Covered Person by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).
PROFESSIONAL PROVIDER - a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are:

A. Audiologist      I. Optometrist
B. Certified Registered Nurse  J. Physical Therapist
C. Chiropractor      K. Physician
D. Dentist       L. Podiatrist
E. Independent Clinical Laboratory M. Psychologist
F. Licensed Clinical Social Worker N. Registered Dietitian
G. Master's Prepared Therapist O. Speech-language Pathologist
H. Nurse Midwife P. Teacher of the Hearing Impaired

PROSTHETICS (or PROSTHETIC DEVICES) – devices (except dental prosthetics), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL - a Facility Provider, approved by the Carrier, 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 he practices; or a Psychologist who is otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

QUALIFYING CLINICAL TRIAL – the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

A. Investigates a service that falls within a benefit category of this Plan;
B. Is not specifically excluded from coverage;
C. Has a therapeutic intent upon enrolled patients with diagnosed disease;
D. Is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;
E. Does not duplicate existing studies;
F. Is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;
G. Is designed and conducted according to appropriate standards of scientific integrity;
H. Complies with Federal regulations relating to the protection of human subjects;
I. Has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;
J. Is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or (2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;
K. Is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider.

In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Carrier as a Qualifying Clinical Trial.
**REASONABLE AND CUSTOMARY** – means the amount that is the usual or customary charge for the service or supply as determined by the Carrier. 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 Carrier determines what is reasonable by the severity and/or complexity of the Covered Person’s condition for which the service or supply is provided.

**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 Carrier, 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** – only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

**RESIDENTIAL TREATMENT FACILITY** - a Facility Provider, licensed and approved by the appropriate government agency and approved by the Carrier, which provides treatment for Mental Illness and Serious Mental Illness or for Alcohol and Drug Abuse and Dependency to partial, outpatient or live-in patients who do not require acute Medical Care.

**ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS** – routine costs include: (a) Covered Services under this Plan that would typically be provided absent a Qualifying Clinical Trial; (b) services and supplies required solely for the provision of the Experimental/Investigative drug, biological product, device, medical treatment or procedure; (c) the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and (d) the services and supplies required for the diagnosis or treatment of complications.

Routine costs do not include the Experimental/Investigative drug, biological product, device, medical treatment or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

**SERIOUS MENTAL ILLNESS** – means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder and delusional disorder.

**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 Carrier and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.
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, which:

A. Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or

B. Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or

C. Is otherwise acceptable to the Carrier.

SPECIALIST SERVICES – all services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

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 Covered Person:

A. CARDIAC REHABILITATION THERAPY - medically supervised rehabilitation program designed to improve a Covered Person's tolerance for physical activity or exercise.

B. CHEMOTHERAPY - treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

C. DIALYSIS - treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. INFUSION THERAPY - treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

E. OCCUPATIONAL THERAPY - medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational Therapy also includes medically prescribed treatment concerned with improving the Covered Person’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 or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

F. 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.

G. 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, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

H. PULMONARY REHABILITATION THERAPY - multidisciplinary treatment which combines Physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

I. RADIATION THERAPY - treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.
J. **SPEECH THERAPY** - medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

**TOTAL DISABILITY (or TOTALLY DISABLED)** – means that a covered Employee, due to illness or injury, cannot perform any duty of his or her occupation or any occupation for which the Employee is, or may be, suited by education, training and experience, and the Employee is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she 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** – Medically Appropriate/Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or-limb threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Covered Person’s health if treatment were delayed.
Your Personal Choice Network Plan (this Plan) is a program, which allows you (a Covered Person) to maximize your health care benefits by utilizing the Personal Choice Preferred Provider Organization's Providers. These Providers are called "Preferred Providers" in this booklet/certificate. You may think of them as "In-Network Providers". Preferred Providers are doctors, Hospitals and other health care professionals and institutions that are part of the Personal Choice Network. Personal Choice Preferred Provider benefits are delivered through a specially selected, highly managed network of cost-effective Providers to ensure quality care. The Personal Choice Network includes Hospitals, Primary Care Providers and specialists, and a wide range of Ancillary Providers, including suppliers of Durable Medical Equipment, Hospice care and Home Health Care Agencies, Skilled Nursing Facilities, Free Standing Dialysis Centers and Ambulatory Surgical Facilities.

When you receive health care through a Provider that is a member of the Personal Choice Network, you are assured of limited out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. You may have to reach a Deductible before receiving benefits and you may be required to file a claim form.

A directory of the Preferred Providers who belong to the Personal Choice Network is available to you upon request. It will identify the Professional Providers who have agreed to become Preferred Professional Providers and will also identify the Hospitals in the Network with which the Preferred Professional Providers are affiliated. Also included in the directory is a listing of the Ancillary Providers affiliated with the Personal Choice Network. The directory is updated periodically throughout the year, and the Carrier 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 the Carrier's Health Resource Center at 1-800-ASK BLUE.

The Carrier covers only care that is Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient department.

Some of the services you receive through this Plan must be Precertified before you receive them, to determine whether they are Medically Appropriate/Medically Necessary. Failure to Precertify Non-Preferred services, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews whether certain procedures/admissions are Medically Appropriate/Medically Necessary. 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. The latest 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 you seek medical treatment that requires Precertification, you are not responsible for obtaining the Precertification if treatment is provided by a Personal Choice Network Provider. In addition, if the Personal Choice Network Provider fails to obtain a required Precertification of services, you will be held harmless from any associated financial Penalties assessed by this Plan as a result. If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

A. Acknowledge this in writing.
B. Request to have services provided.
C. State your willingness to assume financial liability.
When you seek treatment from a Non-Preferred Provider or a BlueCard provider of another Blue Cross or Blue Shield plan, you are responsible for initiating the Precertification process. You should instruct your Provider to call the Precertification number listed on the back of your Identification Card, and give your 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 you.

A. PAYMENT OF PROVIDERS

1. 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 you have any questions about how your health care Provider is compensated, please speak with your healthcare provider directly or contact the Carrier's Member Services Department.

a. 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 Carrier’s Personal Choice fee schedule for the specific medical services that the Physician performs.

b. 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 Covered Person 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, e.g., 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 Carrier 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 Covered Person 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.
c. 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 physicians 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.

d. Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse 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 Carrier’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 (1) vendor arranges for all such services through a contracted set of providers. The Carrier reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of Independence Blue Cross has less than a three percent ownership interest in this mental health/psychiatric care and Alcohol and Drug Abuse vendor.

e. Hospitalists

The Carrier currently does not have a hospitalist program in place but is considering implementing such a program in the future. The Carrier continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing Emergency room consultation and Inpatient management services.

2. Payment Methods

A Covered Person or the Provider may submit bills directly to the Carrier, and, to the extent that benefits and indemnity are payable within the terms and conditions of this Plan, reimbursement will be furnished as detailed below. The Covered Person’s Deductibles, Coinsurance, benefit Maximums and benefits for Covered Services are based on the rate of reimbursement as defined under “Covered Expense” in the Defined Terms section.

a. Facility Providers

(1) Preferred Facility Providers

Preferred Facility Providers are members of the Personal Choice Network and have a contractual arrangement with the Carrier for the provision of services to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for services which have been performed by a Preferred Facility Provider. The Carrier will compensate Preferred Facility Providers in accordance with the contracts entered into between such Providers and the Carrier. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

(2) Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the Personal Choice Network. The Carrier may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network. Non-Preferred Member Facility Providers that have contracts with the Carrier will be compensated in accordance with the contracts entered into between such Providers and the Carrier.
A Non-Preferred Non-Member Facility Provider is a Facility Provider which does not belong to the Personal Choice Network, nor does it have a contract with the Carrier. The Carrier will provide benefits at a Non-Preferred Non-Member Provider at the Non-Preferred coinsurance level specified in the Schedule of Benefits.

If the Carrier determines that Covered Services were for Emergency Care as defined herein, the Covered Person normally will not be subject to the cost-sharing Penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Carrier.

The Carrier will provide benefits for the Covered Expenses incurred for certain medical services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred Facility Provider or a Member Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Carrier.

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

b. Professional Providers

(1) Preferred and Participating Professional Provider Reimbursement

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

Benefit amounts, as specified in the Schedule of Benefits of this coverage, 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 Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to the Carrier for determination. The decision of the Carrier shall be final.

(2) Non-Preferred Professional Provider Reimbursement

When Covered Services are performed by a Non-Preferred Professional Provider, the Carrier will make payment to the Covered Person, subject to any applicable Coinsurance or other cost-sharing Penalty on services by Non-Preferred Professional Providers. When a Covered Person seeks care from a Non-Preferred Participating Professional Provider, payment will be made in accordance with the rate of reimbursement determined by the contract between the Professional Provider and the Carrier. When a Covered Person seeks care from a Non-Preferred, Non-Participating Professional Provider, payment will be the amount as determined by the Carrier's lowest network fee schedule that the Carrier would have paid to a Preferred Professional Provider for the same service, or the charge, whichever is less. Accordingly, when a Covered Person seeks care from Non-Preferred, Non-Participating Professional Providers, any difference between the Non-Preferred Professional Provider's charge and the Carrier's payment shall be the personal responsibility of the Covered Person. This amount may be significant.
If the Carrier determines that services were performed during an Emergency, the Covered Person will not be subject to the cost-sharing features ordinarily applicable to Covered Services rendered by Non-Preferred Professional Providers.

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

c. Ancillary Providers

(1) Preferred Ancillary Providers

Preferred Ancillary Providers include members of the Personal Choice Network that have a contractual relationship with the Carrier for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. The Carrier will compensate Preferred Ancillary Providers in the Personal Choice Network in accordance with the contracts entered into between such Providers and the Carrier. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Ancillary Provider.

(2) Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the Personal Choice Network. Benefits will be provided to the Covered Person at the Non-Preferred coinsurance level specified in the Schedule of Benefits. The Covered Person will be penalized by the application of higher cost-sharing as detailed in the Schedule of Benefits.

d. Assignment of Benefits to Providers

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

B. BLUECARD PPO PROGRAM

When you obtain health care services through BlueCard outside the geographic area QCC Insurance Company (“QCC”) serves, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (“Host Plan”) passes on to us.

Often this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a Covered Person’s liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, QCC would then calculate your liability for any covered health care services in accordance with the applicable Host Blue state statute in effect at the time you received your care.
C. **DEDUCTIBLE**

You must pay a portion of your covered medical expenses before the Carrier begins to pay for benefits. A Deductible must be met each Benefit Period before payment will be made for most Covered Services. See the *Schedule of Benefits* section for the Deductible amount and the services to which the Deductible is applicable.

Expenses incurred for Non-Preferred Services in the last three (3) months of a Benefit Period which were applied to that year’s Non-Preferred Deductible will be applied to the Deductible for the next Benefit Period.

No more than three (3) times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. However, no family member may contribute more than the individual Deductible amount.

D. **COINSURANCE**

Coinsurance is a percentage of the Covered Expenses that must be paid by you or your covered Dependents; it is applied after the Deductible, if any, is met. Coinsurance is applied to most Covered Services, but not to Covered Services that require you to pay a Copayment amount. See the *Schedule of Benefits* for specific Coinsurance amounts.

**Limits on Coinsurance Liability**

There is a Maximum placed on the amount of Coinsurance which you are required to pay each Benefit Period. This Maximum is called your “Out-of-Pocket Coinsurance Limit”. See the *Schedule of Benefits* for the Out-of-Pocket Coinsurance Limit amounts.

When the Non-Preferred Out-of-Pocket Limits are reached, the Carrier will pay 100% of the Covered Expenses for Non-Preferred services Incurred during the balance of the Benefit Period. There is an individual Out-of-Pocket Limit and a family Out-of-Pocket Limit that applies to Non-Preferred Non-Preferred Covered Services. In meeting the family Out-of-Pocket Limit, not more than three (3) times the individual Out-of-Pocket Limit amount must be satisfied by the family members enrolled under one (1) Family Coverage before the Coinsurance is increased to 100% for Covered Services for the remainder of the Benefit Period. However, no family member may contribute more than one individual amount toward the family Out-of-Pocket Limit.

Inpatient and Outpatient Mental Health/Psychiatric Care, your Deductible, if any, and any other Copayments and Penalties do not count toward the Out-of-Pocket Limits.

E. **COPAYMENT**

Copayment is a type of cost-sharing in which the Covered Person pays a flat dollar amount each time an applicable Covered Service is provided. See the *Schedule of Benefits* for Copayment amounts for specific Covered Services. If the Provider’s allowable charge for a Covered Service is less than the Copayment amount, you are only responsible to pay the Provider’s allowable charge. In such a case, the Provider is required to remit any overpayment directly to you.

F. **LIFETIME MAXIMUM**

There is a Lifetime Maximum for all Non-Preferred services. Benefits for Non-Preferred care will cease after the Non-Preferred Lifetime Maximum is reached.

See the *Schedule of Benefits* for Lifetime Maximum amount. Amounts applied to the Covered Person’s Lifetime Maximum are not restorable.
G. HOW TO FILE A CLAIM

You are never required to file a claim when Covered Services are provided by Preferred Providers. When you receive care from a Non-Preferred Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the Carrier's Member Services Department at the number listed on the back of your Identification Card, and a claim form will be sent to you. Fill out the claim form and return it with your itemized bills to the Carrier at the address listed on the claim form no later than twenty (20) days after completion of the Covered Services. The claim should include the date and information required by the Carrier 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, your benefits will not be reduced, but in no event will the plan be required to accept the claim more than two (2) years after the end of the Benefit Period in which the Covered Services are rendered.
Effective Date: The date the Group agrees that all eligible persons may apply and become covered for the benefits as set forth in this Plan and described in this booklet/certificate. If a person becomes an eligible person after the Group’s Effective Date, that date becomes the eligible person’s effective date under this Plan.

ELIGIBLE PERSON

You are eligible to be covered under this Plan if you are determined by the Group as eligible to apply for coverage and sign the Application.

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

ELIGIBLE DEPENDENT

Your family is eligible for coverage (Dependent coverage) under this Plan when you are eligible for Employee coverage. An eligible Dependent is defined as your spouse under a legally valid existing marriage, your unmarried child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. The limiting age for covered, unmarried children is age 19; or if a full-time student in an Accredited Educational Institution, the attainment of age 23. Dependent coverage will terminate at the end of the month in which the child attains limiting age.

A full-time student who is eligible for coverage under this plan who is (1) 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 (2) 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 Carrier approved by the Department of Military & Veterans Affairs (DMVA): (1) notifying the Carrier that the Dependent has been placed on active duty; (2) notifying the Carrier that the Dependent is no longer on active duty; (3) 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 or physical incapacitation and who are dependent on you for over half of their support. The Carrier may require proof of eligibility under the prior carrier’s plan and also from time to time under this Plan.

The newborn child(ren) of you or your Dependent shall be entitled to the benefits provided by this Plan from the date of birth for a period of thirty-one (31) days. Coverage of newborn children within such thirty-one (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 thirty-one (31) day period, you must enroll the newborn child within such thirty-one (31) days. To continue coverage beyond thirty-one (31) days for a newborn child, who does not otherwise qualify for coverage as a Dependent, you must apply within thirty-one (31) days after the birth of the newborn and the appropriate rate must be paid when billed.
A newly acquired Dependent shall be eligible for coverage under this Plan on the date the Dependent is acquired provided that you apply to the Carrier for addition of the Dependent within thirty-one (31) days after the Dependent is acquired and you make timely payment of the appropriate rate. If Application is made later than thirty-one (31) days after the Dependent is acquired, coverage shall become effective on the first billing date following thirty (30) days after your Application is accepted by the Carrier.

A Dependent child of a custodial parent covered under this Plan 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 (1) 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.
Subject to the exclusions, conditions and limitations of this Plan, a Covered Person is entitled to benefits for the
Covered Services described in this Description of Benefits 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 Benefits.

Covered Services may be provided by either a Preferred or Non-Preferred Provider. However, the Covered Person will
maximize the benefits available when Covered Services are provided by a Provider that belongs to the Personal Choice
Network (a Preferred Provider) and has a contract with the Carrier to provide services and supplies to the Covered
Person. The Covered Person will be held harmless for out of network differentials if: a Preferred Provider fails to
provide written notice to the Covered Person of the Provider’s Non-Preferred status for certain services; or, a Preferred
Provider provides a written order for certain services to be performed by a Preferred Provider that has Non-Preferred
status for those services and that Provider performs such service. The Your Personal Choice Network Plan section
provides more detail regarding Preferred and Non-Preferred 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 Covered Person receives the services. Precertification of
services is a vital program feature that reviews Medical Appropriateness/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 Your Personal Choice Network Plan and the Managed Care
sections. Covered Services that require Precertification, and any Penalty for failure to obtain a Precertification, are
specified on the Schedule of Benefits.

PRIMARY AND PREVENTIVE CARE

A Covered Person is entitled to benefits for Primary Care and “Preventive Care” Covered Services when deemed
Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and
any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

“Preventive Care” services generally describe health care services performed to catch the early warning signs of health
problems. These services are performed when the Covered Person has no symptoms of disease. Services performed
to treat an illness or injury are not covered as Preventive Care under this benefit.

The Carrier periodically reviews the schedule of Covered Services 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. The Carrier reserves the right to modify the schedule at any time after written notice of the change has been
given to the Covered Person.

A. Office Visits

Medical care visits for the examination, diagnosis and treatment of an illness or injury by a Primary Care
Provider. 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 Covered Person’s residence, or medical care consultations by a Provider on an
Outpatient basis.
B. Pediatric Preventive Care

Pediatric Preventive Care includes the following:

1. **Physical Examination, Routine History, Routine Diagnostic Tests.** Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e., 2-3 months), the dash indicates that coverage is available for one service from two (2) months through three (3) months of age.

   Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:
   - Eight (8) exams between the ages of 0-24 months within the following age ranges:
     - 0-1 month    9-11 months
     - 2-3 months   12-14 months
     - 4-5 months   15-17 months
     - 6-8 months   18-24 months
   - One (1) exam every calendar year between two (2) and seventeen (17) years of age

2. **Blood Lead Screening.** This blood test detects elevated lead levels in the blood. Children are covered for:
   - One (1) test between 9-12 months of age
   - One (1) test at twenty-four (24) months of age

3. **Hemoglobin/Hematocrit.** This blood test measures the size, shape, number and content of red blood cells. Children are covered for:
   - One (1) test between 0-12 months of age
   - One (1) test between one (1) and four (4) years of age
   - One (1) test between five (5) and twelve (12) years of age
   - One (1) test between thirteen (13) and seventeen (17) years of age

4. **Rubella Titer Test.** The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.

5. **Urinalysis.** This test detects numerous abnormalities. Children are covered for:
   - One (1) test every 365 days between 0-24 months of age
   - One (1) test every calendar year between two (2) and seventeen (17) years of age

C. Pediatric Immunizations

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Benefits are limited to Covered Persons under twenty-one (21) years of age.
D. Adult Preventive Care

1. **Physical Examination, Routine History.** Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons eighteen (18) years of age or older in accordance with the following schedule:

   - One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
   - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
   - One (1) examination every calendar year, beginning at forty (40) years of age

2. **Adult Tetanus Toxoid (TD).** This immunization provides immunity against tetanus and diphtheria.

   - One (1) test every ten (10) calendar years, beginning at eighteen (18) years of age

3. **Blood Cholesterol Test.** This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.

   - One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
   - One (1) examination every calendar year, beginning at forty (40) years of age

4. **Complete Blood Count (CBC).** This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.

   - One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
   - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
   - One (1) test every calendar year, beginning at forty (40) years of age

5. **Fecal Occult Blood Test.** This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.

   - One (1) test every calendar year, beginning at fifty (50) years of age

6. **Flexible Sigmoidoscopy.** This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.

   - One (1) test every three (3) calendar years, beginning at fifty (50) years of age

7. **Influenza Vaccine.** This vaccine provides immunization against influenza type A and B viruses.

   - One (1) vaccine every calendar year, beginning at eighteen (18) years of age

8. **Pneumococcal Vaccine.** This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.

   - One (1) vaccine every five (5) calendar years, beginning at sixty-four (64) years of age

9. **Prostate Specific Antigen (PSA).** This blood test may be used to detect tumors of the prostate.

   - One (1) test every calendar year, beginning at fifty (50) years of age

10. **Routine Colonoscopy.** This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.

    - One (1) test every ten (10) calendar years, beginning at fifty (50) years of age
11. **Rubella Titer Test.** The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the adult has ever been immunized.

- One (1) test and immunization between eighteen (18) and forty-nine (49) years of age

12. **Thyroid Function Test.** This test detects hyperthyroidism and hypothyroidism.

- One (1) series of tests every calendar year, beginning at eighteen (18) years of age

13. **Urinalysis.** This test detects numerous abnormalities.

- One (1) test every calendar year, beginning at eighteen (18) years of age

14. **Varicella Vaccine.** This vaccine is recommended for women of childbearing age who have not been previously exposed to the chicken pox virus.

- One (1) immunization for women between eighteen (18) and forty-nine (49) years of age

15. **Fasting Blood Glucose Test.** This test is used for detection of diabetes

- One (1) test every three (3) years, beginning at age forty-five (45).

16. **Abdominal Aortic Aneurysm screening.** One (1) test per lifetime is recommended for men with a smoking history.

- One (1) ultrasound for men between sixty-five (65) and seventy-five (75) years of age.

17. Benefits are also payable for certain immunizations provided to Covered Persons determined to be at “high risk” as determined by the Carrier.

**E. Routine Gynecological Examination, Pap Smear**

Female Covered Persons are covered for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

**F. Mammograms**

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

**G. Osteoporosis Screening (Bone Mineral Density Testing or BMDT)**

Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

- One screening test every two calendar years beginning at age 65

**H. Nutrition Counseling for Weight Management**

Coverage will be provided for any Covered Person for nutrition counseling visits in an office setting for the purpose of weight management, up to the Maximum visit limit as specified in the *Schedule of Benefits.*
INPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services while an Inpatient in a Facility Provider when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

A. Hospital Services

1. Ancillary Services

   Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including, but not limited to, the following:

   a. Meals, including special meals or dietary services as required by the Covered Person’s condition;
   b. Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
   c. Casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
   d. Oxygen and oxygen therapy;
   e. Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
   f. Cardiac Rehabilitation Therapy, Chemotherapy, Dialysis, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation Therapy, Radiation Therapy, respiratory therapy, and Speech Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
   g. All drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;
   h. Use of special care units, including, but not limited to, intensive or coronary care; and
   i. Pre-admission testing.

2. Room and Board

   Benefits are payable for general nursing care and such other services as are covered by the Hospital’s regular charges for accommodations in the following:

   a. An average semi-private room, as designated by the Hospital; or a private room, when designated by the Carrier as semi-private for the purposes of this plan in Hospitals having primarily private rooms;
   b. A private room, when Medically Appropriate/Medically Necessary;
   c. 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;
   d. A bed in a general ward; and
   e. Nursery facilities.

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

   In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

   A Copayment may apply to a Preferred Inpatient Admission, if specified in the Schedule of Benefits. For purposes of calculating the total Copayment due, an admission occurring within ninety (90) days of discharge from a previous admission shall be treated as part of the previous admission.

   Days available shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (a) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (b) after the discharge hour that the Covered Person’s attending Physician has recommended that further Inpatient care is not required.
B. Medical Care

Medical Care rendered by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Professional Provider’s constant attendance and treatment for a prolonged period of time.

1. Concurrent Care

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or 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.

2. Consultations

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider’s rules and regulations. Benefits are limited to one (1) consultation per consultant during any Inpatient confinement.

C. Skilled Nursing Care Facility

Benefits are provided for a Skilled Nursing Care Facility, when Medically Appropriate/Medically Necessary as determined by the Carrier, up to the Maximum days specified in the Schedule of Benefits. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Facility.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one (1) day.

Days available shall be allowed only during uninterrupted stays in a Skilled Nursing Care Facility. Benefits shall not be provided: (a) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (b) after the discharge hour that the Covered Person’s attending Physician has recommended that further Inpatient care is not required.

Medically Appropriate/Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the Schedule of Benefits.

No Skilled Nursing Care Facility benefits are payable:

1. When confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;
2. For the treatment of Alcohol and Drug Abuse or dependency, and mental illness; or
3. After the Covered Person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.

INPATIENT/OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services either while an Inpatient in a Facility Provider or on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.
A. Blood

Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage or transfusion - i.e., an individual having his own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for 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.

B. Hospice Services

When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six (6) months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with a terminal illness rather than cure it. Hospice Care provides services to make the Covered Person as comfortable and pain-free as possible. When a Covered Person elects to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice Care at any time.

Respite Care: When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person’s home. Up to seven (7) days of such care every six (6) months will be covered.

Benefits for Covered Hospice Services shall be provided until the earlier of the Covered Person’s death or discharge from Hospice Care.

Special Hospice Services Exclusions: No Hospice Care benefits will be provided for:

1. Services and supplies for which there is no charge;
2. Research studies directed to life lengthening methods of treatment;
3. Services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
4. Care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

C. Maternity/OB-GYN/Family Services

1. Maternity/Obstetrical Care

Services rendered in the care and management of a pregnancy for a Covered Person are a Covered Expense under this Plan as specified in the Schedule of Benefits. Prenotification of maternity care should occur within one (1) month of the first prenatal visit to the Physician or midwife. Benefits are payable for: (1) facility services provided by a Hospital or Birth Center; and (2) professional services performed by a Professional Provider or certified nurse midwife.

Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the Carrier as provided for in the Managed Care section.

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.
2. **Newborn Care**

The newborn child of a Covered Person shall be entitled to benefits provided by this Plan from the date of birth up to a maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond thirty-one (31) days under conditions specified in the *Eligibility Under This Plan* section.

3. **Artificial Insemination**

Services performed by a Professional Provider for the promotion of fertilization of a female 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.

D. **Mental Health/Psychiatric Care**

Benefits for the treatment of Mental Illness and Serious Mental Illness are based on the services provided and reported by the Provider. Those services provided by and reported by the Provider as Mental Health/Psychiatric Care are subject to the mental Health/Psychiatric Care limitations shown in the *Schedule of Benefits*. When a Provider renders Medical Care, other than Mental Health/Psychiatric Care, for a Covered Person 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.

Preauthorization information must be submitted by the Provider to the Carrier for review and evaluation so a Plan of Treatment may be Precertified for the Covered Person. Precertification must be obtained for all treatment, other than Emergency Care in order to assure the Medical Appropriateness/Medical Necessity of the proposed treatment based on the nature and severity of the Covered Person’s condition. A personal assessment by a Preferred Professional Provider will be provided by the Carrier at no cost to the Covered Person to accommodate the Precertification process. Emergency Care is exempt from the requirements for Precertification and will be considered Preferred Care. However, Emergency admissions or services must be reviewed and authorized within two (2) business days of the admission or services, or as soon as possible as determined by the Carrier.

1. **Inpatient Treatment**

Benefits are provided, subject to the Benefit Period limitations stated in the *Schedule of Benefits*, for an Inpatient Admission for treatment of Mental Illness and Serious Mental Illness. For maximum benefits, treatment must be received from a Preferred Facility Provider and Inpatient visits for the treatment of mental illness and Serious Mental Illness must be performed by a Preferred 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 a Preferred Inpatient Admission, if specified in the *Schedule of Benefits*. For purposes of calculating the total Copayment due, an admission occurring within ninety (90) days of discharge from a previous admission shall be treated as part of the previous admission.

2. **Outpatient Treatment**

Benefits are provided, subject to the Benefit Period limitations shown in the *Schedule of Benefits*, for Outpatient treatment of Mental Illness and Serious Mental Illness. Outpatient Mental Health/Psychiatric Care shall be covered for the full number of Outpatient session visits or an equivalent number of Partial Hospitalization visits per Benefit Period. For treatment of mental illness, the Covered Person may trade off: (a) on a one (1) for two (2) basis, Inpatient days for additional separate Partial Hospitalization services; or (b) on a one (1) for four (4) basis, Inpatient days for additional Outpatient visits. See the *Schedule of Benefits* for limits on the number of Inpatient days that may be exchanged in any Benefit Period. For treatment of Serious Mental Illness, the Covered Person may trade on a one (1) for two (2) basis, Inpatient days for additional Outpatient Partial Hospitalization days/Outpatient session visits. For maximum benefits, treatment must be performed by a Preferred Professional Provider/Preferred 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, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

3. **Benefits are not payable for the following services:**

   a. Vocational or religious counseling;
   b. Activities that are primarily of an educational nature;
   c. Treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy, and obesity control therapy.

4. **Benefit Period Maximums for Mental Health/Psychiatric Care**

   All Inpatient and Outpatient Mental Health/Psychiatric Care for both mental illness and Serious Mental Illness are covered up to the Maximum day and visit limitation amounts per Benefit Period specified in the Schedule of Benefits. Non-Preferred Benefit Period maximums are part of, not separate from, Preferred Benefit Period maximums.

E. **Routine Costs Associated With Qualifying Clinical Trials**

   Benefits are provided for Routine Costs Associated With Participation in a Qualifying Clinical Trial (see the Defined Terms section). To ensure coverage, the Carrier must be notified in advance of the Covered Person’s participation in a Qualifying Clinical Trial.

F. **Surgical Services**

   Surgery benefits will be provided for services rendered by a Professional Provider and/or 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. Also covered is: (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy.

   Coverage is also provided for: (1) the surgical procedure performed in connection with the initial and subsequent, insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (2) the treatment of physical complications at all stages of the mastectomy, including lymphedemas. Treatment of lymphedema is not subject to any benefit Maximum amounts that apply to “Physical Therapy” services as provided under subsection entitled “Therapy Services”.

   Covered surgical procedures shall include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

1. **Hospital Admission for Dental Procedures or Dental Surgery**

   The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

   Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Appropriate/Medically Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the “Oral Surgery” terms of this Plan will be covered during such a confinement.
2. **Oral Surgery**

Benefits will be payable for Covered Services provided by a Professional Provider and/or Facility Provider for:

a. 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:

   (1) The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.

   (2) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.

   (3) 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.

b. Other oral surgery - defined as surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Benefits will be provided only for:

   (1) Surgical removal of impacted teeth which are partially or completely covered by bone;

   (2) The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and

   (3) Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

3. **Assistant at Surgery**

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery. Benefits will be provided for an assistant at Surgery only if an intern, resident, or house staff member is not available.

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. **Anesthesia**

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 booklet/certificate).

5. **Second Surgical Opinion (Voluntary)**

Consultations for Surgery to determine the Medical Appropriateness/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.
G. Transplant Services

When a Covered Person 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 Covered Person 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 Covered Person:

1. When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this Plan.

2. When only the recipient is a Covered Person, both the donor and the recipient are entitled to the benefits of this Plan. 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 Carrier or any government program. Benefits provided to the donor will be charged against the recipient’s coverage under this Plan.

3. When only the donor is a Covered Person, no benefits will be provided for Transplant Services.

4. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

H. Treatment for Alcohol or Drug Abuse and Dependency

Alcohol or Drug Abuse and dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal.

Benefits are payable for the care and treatment of Alcohol or Drug Abuse and dependency provided by a Hospital or Facility Provider, subject to the Maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from a Preferred Provider.

Pre-authorization information must be submitted by the Provider to the Carrier for review and evaluation so a Plan of Treatment may be Precertified for the Covered Person. Precertification must be obtained for all treatment, other than Emergency Care in order to assure the Medical Appropriateness/Medically Necessity of the proposed treatment based on the nature and severity of the Covered Person’s condition. A personal assessment by a Preferred Professional Provider will be provided by the Carrier at no cost to the Covered Person to accommodate the Precertification process. Emergency Care is exempt from the requirements for Precertification. However, Emergency admissions or services must be reviewed and authorized within two (2) business days of the admission or services, or as soon as possible as determined by the Carrier.

Precertification must be obtained for all Plans of Treatment. Emergency admissions must be certified within two (2) days, or as soon as possible as determined by the Carrier.

1. Inpatient Treatment

   a. Inpatient Detoxification

   Inpatient Covered Services for Detoxification shall be covered for seven (7) days per admission for Detoxification with a Lifetime Maximum of four (4) admissions for Detoxification per Covered Person.

   Covered Services include:

   (1) Lodging and dietary services;
   (2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
   (3) Diagnostic x-rays;
   (4) Psychiatric, psychological and medical laboratory testing;
   (5) Drugs, medicines, use of equipment and supplies.
A Copayment may apply to a Preferred Inpatient Admission, if specified in the Schedule of Benefits. For purposes of calculating the total Copayment due, an admission occurring within ninety (90) days of discharge from a previous admission shall be treated as part of the previous admission.

b. 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 Plan, but services are limited to thirty (30) days per Benefit Period. The lifetime Maximum number of days per Covered Person for this benefit is shown in the Schedule of Benefits.

Covered services include:

(1) Lodging and dietary services;
(2) Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
(3) Rehabilitation therapy and counseling;
(4) Family counseling and intervention;
(5) Psychiatric, psychological and medical laboratory testing;
(6) Drugs, medicines, use of equipment and supplies.

A Copayment may apply to a Preferred Inpatient Admission, if specified in the Schedule of Benefits. For purposes of calculating the total Copayment due, an admission occurring within ninety (90) days of discharge from a previous admission shall be treated as part of the previous admission.

2. Outpatient Treatment

Outpatient Alcohol or Drug Services shall be covered for sixty (60) full Outpatient session visits or an equivalent number of Partial Hospitalization visits per Benefit Period. Thirty (30) of the sixty (60) separate sessions of Outpatient or Partial Hospitalization services may be exchanged on a two (2) to one (1) basis to receive up to fifteen (15) more days of Non-Hospital Residential Alcohol or Drug Abuse Treatment (i.e., the Covered Person may trade off on a two (2) for one (1) basis up to thirty (30) separate sessions of Outpatient services per Benefit Period in order to receive up to fifteen (15) additional days of Hospital and Non-Hospital Residential Alcohol or Drug Abuse Treatment days). Any benefits exchanged or traded off under terms of this provision are subject to, and do not increase, the overall Lifetime Maximum.

The lifetime Maximum number of days per Covered Person for this benefit is shown in the Schedule of Benefits.

Covered services include:

a. Diagnosis and treatment of Substance Abuse, including Outpatient Detoxification;
b. Physician, Psychologist, nurse, certified addictions counselor and trained staff services;
c. Rehabilitation therapy and counseling;
d. Family counseling and intervention;
e. Psychiatric, psychological and medical laboratory testing;
f. Drugs, medicines, use of equipment and supplies.

OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.
A. Ambulance Services

Benefits are provided for ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Carrier, for transportation in a specially designed and equipped vehicle used only to transport the sick or injured, but only when:

1. the vehicle is licensed as an ambulance where required by applicable law;
2. the ambulance transport is appropriate for the patient’s clinical condition;
3. 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 be contraindicated (i.e. would endanger the patient’s medical condition); and,
4. the ambulance transport satisfies the destination and other requirements stated below in either “A. For Emergency Ambulance transport” or “B. For Non-Emergency Ambulance transport”.

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

A. For Emergency Ambulance transport

The ambulance must be transporting the Covered Person from the Covered Person’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 Appropriate/Medically Necessary Covered Services for the Covered Person’s condition.

B. Day Rehabilitation Program

Subject to the limits shown in the Schedule of Benefits, benefits will be provided for a Medically Appropriate/Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

1. The Covered Person requires intensive Therapy services, such as Physical, Occupational and/or speech Therapy five (5) days per week for 4-7 hours per day;
2. The Covered Person has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;
3. The Covered Person is willing to participate in a Day Rehabilitation Program; and
4. The Covered Person’s family must be able to provide adequate support and assistance is the home and must demonstrate the ability to continue the rehabilitation program in the home.

C. Diabetic Education Program

Benefits are provided 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 prescribed by a Professional Provider legally authorized to prescribe such items under law.
The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the Covered Person's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Preferred Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Carrier. These requirements are based on the certification programs for Outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

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

1. Initial assessment of the Covered Person's needs;
2. Family involvement and/or social support;
3. Psychological adjustment for the Covered Person;
4. General facts/overview on diabetes;
5. Nutrition including its impact on blood glucose levels;
6. Exercise and activity;
7. Medications;
8. Monitoring and use of the monitoring results;
9. Prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
10. Use of community resources; and
11. Pregnancy and gestational diabetes, if applicable.

D. Diabetic Equipment and Supplies

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or Precertification requirements applicable to Durable Medical Equipment benefits, for diabetic equipment and supplies purchased from a Durable Medical Equipment Provider. If this Plan provides benefits for prescription drugs (other than coverage for insulin and oral agents only), Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, subject to the cost-sharing arrangements applicable to the prescription drug coverage.

1. Diabetic Equipment
   a. Blood glucose monitors;
   b. Insulin pumps;
   c. Insulin infusion devices; and
   d. Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

2. Diabetic Supplies
   a. Blood testing strips;
   b. Visual reading and urine test strips;
   c. Insulin and insulin analogs*;
   d. Injection aids;
   e. Insulin syringes;
   f. Lancets and lancet devices;
   g. Monitor supplies;
   h. Pharmacological agents for controlling blood sugar levels;* and
   i. Glucagon emergency kits.

*If this Plan does not provide coverage for prescription drugs, insulin and oral agents are covered as provided under the “Insulin and Oral Agents” benefits.
E. Diagnostic Services

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

1. Routine Diagnostic Services, including routine radiology (consisting of x-rays, ultrasound, and nuclear medicine), routine medical procedures (consisting of ECG, EEG, and other diagnostic medical procedures approved by the Carrier), and allergy testing (consisting of percutaneous, intracutaneous and patch tests).

2. Non-Routine Diagnostic Services, including MRI/MRA, CT Scans, and PET Scans.

3. Diagnostic laboratory and pathology tests.

4. Genetic testing including those testing services provided to a Covered Person at risk by pedigree for a specific hereditary disease. The services must be for the purpose of diagnosis and where the results will be used to make a therapeutic decision.

F. Durable Medical Equipment

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Carrier, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Appropriate/Medically Necessary by the Carrier.

Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance. Therefore, Precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment that exceeds the amount shown in the Schedule of Benefits.

Durable Medical Equipment, as defined in the Defined Terms section, includes equipment that meets the following criteria:

1. It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered “durable”. (For examples, see item 4 under “Durable Medical Equipment Exclusions” below.)

2. It customarily and primarily serves a medical purpose.

3. 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 Covered Person’s illness, injury, or to improvement of a malformed body part.

4. It is appropriate for home use.

Durable Medical Equipment Exclusions: Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

1. Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.

2. Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants.

3. Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, transfist chairs and traction units.
4. **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. Items not covered include, but are not limited to, incontinence pads, lambs wool pads, ace bandages, antiembolism stockings, catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits.

5. **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, ear plugs, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils, toileting systems, electronically-controlled heating and cooling units for pain relief, toilet seats, bathtub lifts, stairglides, and elevators.

6. **Equipment with features of a medical nature** which are not required by the Covered Person’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 Appropriate/Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.

7. **Duplicate equipment** for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.

8. **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.

9. **Modifications to vehicles, dwellings and other structures.** This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Covered Person’s disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as a wheelchair.

Replacement and repair: The Carrier will provide benefits for the replacement of Durable Medical Equipment: (a) when there has been a change in the Covered Person’s condition that requires the replacement, (b) if the equipment breaks because it is defective, or (c) it breaks because it exceeds its life expectancy, as determined by the manufacturer. If an item breaks and is under warranty, unless it is a rental item, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

The Carrier 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. The Carrier will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

G. **Emergency Care Services**

Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility are provided by the Carrier at the Preferred level of benefits, regardless of whether the patient is treated by a Preferred or Non-Preferred Provider. If Emergency Services are required, whether the Covered Person 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.

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. Outpatient follow-up care provided in a Medically Appropriate/Medically Necessary setting (in Emergency Room, other Outpatient Emergency Facility or physician’s office) are also covered if received within 14 days of the initial Outpatient Emergency Care, as specified above.
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 Carrier. Should any dispute arise as to whether an Emergency existed or as to the duration of an Emergency, the determination by the Carrier shall be final.

H. Home Health Care

Benefits will be provided for the following services when performed by a licensed Home Health Care Agency:

1. Professional services of appropriately licensed and certified individuals;
2. Intermittent skilled nursing care;
3. Physical Therapy;
4. Speech Therapy;
5. Well mother/well baby care following release from an Inpatient maternity stay; and
6. Care within forty-eight (48) hours following release from an Inpatient Admission when the discharge occurs within forty-eight (48) hours following a mastectomy.

With respect to Item 5 above, Home Health Care services will be provided within forty-eight (48) hours if discharge occurs earlier than forty-eight (48) hours of a vaginal delivery or ninety-six (96) hours of a cesarean delivery. No Deductible, Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include Occupational Therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Carrier.

Home Health Care benefits will be provided only when prescribed by the Covered Person’s attending Physician in a written Plan of Treatment and approved by the Carrier as Medically Appropriate/Medically Necessary.

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.

With the exception of Home Health Care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be Homebound in order to be eligible to receive Home Health Care benefits. For purposes of this Home Health care benefit, the following definitions apply:

**HOME** – means a Covered Person’s place of residence (e.g. private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility (SNF) at a custodial level of care.

**HOMEBOUND** – means there exists a normal inability to leave home due to severe restrictions on the Covered Person’s mobility and when leaving the home: (a) it would involve a considerable and taxing effort by the Covered Person; and (b) the Covered Person is unable to use transportation without another’s assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

Home Health Care Exclusions: No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

1. Custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
2. Rental or purchase of Durable Medical Equipment;
3. Rental or purchase of medical appliances (e.g. braces) and Prosthetic Devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
4. Prescription drugs;
5. Services provided by a member of the Covered Person’s Immediate Family;
6. Covered Person’s transportation, including services provided by voluntary ambulance associations for which the Covered Person is not obligated to pay;
7. Emergency or non-Emergency Ambulance services;
8. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to
diversional Occupational Therapy and/or social services;
9. Services provided to individuals (other than a Covered Person released from an Inpatient maternity stay),
who are not essentially homebound for medical reasons; and
10. Visits by any Provider personnel solely for the purpose of assessing a Covered Person’s condition and
determining whether or not the Covered Person requires and qualifies for Home Health Care services and
will or will not be provided services by the Provider.

I. Injectable Medications

Benefits will be provided for injectable medications required in the therapeutic treatment of an injury or illness,
prescribed by a Professional Provider, and required for therapeutic use when determined to be Medically
Appropriate/Medically Necessary by the Carrier. The administration of injectable medications is determined by
the dosage regimen of the medication and the Physician prescribed treatment plan.

1. Biotech/Specialty Injectables

Refers to injectable medications included in the following list of Biotech/Specialty Injectables.
Precertification is required for all Biotech/Specialty Injectables listed. This list is subject to change as
new injectable medications come to market. The purchase of all Biotech/Specialty Injectables is subject
to a Copayment if dispensed by a Preferred Provider or Coinsurance if dispensed by a Non-Preferred
Provider. The Copayment and Coinsurance amounts are shown in the Schedule of Benefits. Copayment
and Coinsurance amounts will apply: (a) to each thirty (30) day supply of medication dispensed for
medications administered on a regularly scheduled basis; or (b) to each course/series of injections if
administered on an intermittent basis.

A ninety (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 Covered Person will be subject to three (3) Copayments,
if applicable.

Biotech/Specialty Injectables:

Anticoagulant/Low Molecular Weight Heparin Agents:
- Arixtra, Fragmin, Innohep, Lovenox,
Antiretroviral Agents
- Fuzeon
Botulinum Toxin Agents
- Botox, Myobloc
Central Nervous System Agents
- Imitrex, Apokyn
Endocrine/Metabolic Agents
- Eligard, Faslodex, Forteo, Lupron, Sandostatin, Somavert, Thyrogen, Trelstar, Vantas,
- Viadur, Zoladex
Growth Hormones and related agents
- Genotropin, Humatrope, Increlex, Norditropin, Nutropin/Nutropin AQ, Omnitrope, Saizen,
- Serostim/Serostim LQ, Tev-Tropin, Zortptive
Hematopoietic Agents
- Aranesp, Epogen, Leukine, Neulasta, Neumega, Neupogen, Procrit
Hepatitis/Interferon Alfa Agents
- Actimmune, Alferon N, Interfergen, Intron A, Pegasys, PEG Intron, Roferon-A
Hyaluronate Agents
- Euflexxa, Hyalgan, Orthovisc, Supartz, Synvisc
Immunological Modifiers
- Amevive, Enbrel, Humira, Kineret, Raptiva
Intra-Ocular Agents
- Lucentis, Macugen, Vitraset
Multiple Sclerosis Agents/Interferon Beta Agents
- Avonex, Betaseron, Copaxone, Rebif
Respiratory Agents
- Synagis, Xolair
2. **Standard Injectables**

Refers to all other injectable medications including, but not limited to, allergy injections and extractions and injectable medications only administered in a Physician’s office such as antibiotic and steroid injections.

J. Insulin and Oral Agents

Benefits will be provided 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 thirty (30) day supply when dispensed from a retail pharmacy.

K. Medical Foods and Nutritional Formulas

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an Outpatient basis either orally or through a tube.

Benefits are also payable for Nutritional Formulas when: (1) they are the sole source of nutrition for an individual (more than 75% of estimated basal caloric requirement) and the Nutritional Formula is given by way of a tube into the alimentary tract, or (2) the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable 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 plan.

L. Non-Surgical Dental Services (Dental Services as a Result of Accidental Injury)

Benefits will be provided only for the initial treatment of Accidental Injury/trauma, (i.e. 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, including the first caps, crowns, bridges and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury. (See the exclusion of dental services in the What Is Not Covered section for more information on what dental services are not covered);

M. Orthotics

Benefits are provided for:

1. The initial purchase and fitting (per medical episode) of orthotic devices which are Medically Appropriate/Medically Necessary as determined by the Carrier, except foot orthotics unless the Covered Person requires foot orthotics as a result of diabetes.

2. The replacement of covered orthotics for Dependent children when required due to natural growth.

N. Podiatric Care

Benefits are provided for podiatric care including: capsular or surgical treatment of bunions; ingrown toenail surgery; and other non-routine Medically Necessary/Medically Appropriate foot care. In addition, for Covered Persons with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, benefits for routine foot care services are provided.
O. Private Duty Nursing Services

Benefits will be provided up to the number of hours specified in the Schedule of Benefits 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 Appropriate/medically Necessary as determined by the Carrier.

Benefits are not payable for:

1. Nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;

2. Services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family; and

3. Services provided by a home health aide or a nurse's aide.

P. Prosthetic Devices

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 Carrier to determine eligibility and Medical Appropriateness/Medical Necessity.

Such expenses may include, but not be limited to:

1. 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; and

2. The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device;

3. 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

4. Benefits are provided for the following visual Prosthetics when Medically Appropriate/Medically Necessary and prescribed for one of the following conditions:
   a. Initial contact lenses prescribed for treatment of infantile glaucoma;
   b. Initial pinhole glasses prescribed for use after surgery for detached retina;
   c. Initial corneal or scleral lenses prescribed (1) in connection with the treatment of keratoconus; or (2) to reduce a corneal irregularity other than astigmatism;
   d. Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
   e. Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of (1) Accidental Injury; (2) trauma, or (3) ocular surgery.

Benefits are not provided for:

a. Lenses which do not require a prescription;
b. Any lens customization such as, but not limited to tinting, oversize or progressive lenses, antireflective coatings, U-V lenses or coatings, scratch resistance coatings, mirror coatings, or polarization;

The repair and replacement provisions do not apply to this item (4).

Benefits for replacement of a Prosthetic Device or its parts will be provided: (a) when there has been a significant change in the Covered Person’s medical condition that requires the replacement, (b) if the prostheses breaks because it is defective, or (c) if the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer, or (d) for a Dependent child due to the normal growth process when Medically Appropriate/Medically Necessary.
The Carrier 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 a prosthesis, replacement means the removal and substitution of the prosthesis or one of its components necessary for proper functioning. A repair is a restoration of the prosthesis or one of its components to correct problems due to wear or damage. However, the Carrier will not provide benefits for repairs and replacements needed because the prosthesis was abused or misplaced.

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

Q. Specialist Office Visit

Benefits will be provided for Specialist Service 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 a Covered Person’s residence, or medical care consultations by a Provider on an Outpatient basis.

R. Spinal Manipulation Services

Benefits shall be provided up to the limits specified in the Schedule of Benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

S. Therapy Services

Benefits shall be provided, subject to the Benefit Period Maximums specified in the Schedule of Benefits, 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 Covered Person.

1. Cardiac Rehabilitation Therapy

Refers to a medically supervised rehabilitation program designed to improve a patient’s tolerance for physical activity or exercise.

2. Chemotherapy

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes). The cost of drugs, approved by the Federal Food and Drug Administration (FDA) and only for those uses for which such drugs have been specifically approved by the FDA as antineoplastic agents is covered, provided they are administered as described in this paragraph.

3. 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 cyclic peritoneal dialysis (CCPD).

4. Infusion Therapy

Treatment includes, but is not limited to, infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.
5. **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.

6. **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.

7. **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.

8. **Physical Therapy**

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, biomechanical 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.

9. **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.

10. **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.
What Is Not Covered

Except as specifically provided in this booklet/certificate, no benefits will be provided for services, supplies or charges:

- Which are not Medically Appropriate/Medically Necessary as determined by the Carrier for the diagnosis or treatment of illness or injury;
- Which are Experimental/Investigative in nature;
- Which were Incurred prior to the Covered Person’s effective date of coverage;
- Which were or are Incurred after the date of termination of the Covered Person’s coverage except as provided in the General Information section;
- For any loss sustained or expenses Incurred 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;
- For which a Covered Person 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;
- 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 Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
- 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 the Worker’s Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
- To the extent a Covered Person 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 Covered Person;
- 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;
- Which are not billed and performed by a Provider as defined under this coverage as a “Professional Provider”, “Facility Provider” or “Ancillary Provider” except as otherwise indicated under the subsections entitled: (a) Therapy Services” (that identifies covered therapy services as provided by licensed therapists) and (b) “Ambulance Services” in the Description of Benefits;
- Rendered by a member of the Covered Person’s Immediate Family;
- 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 ambulance services except as specifically provided under this Plan;
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. Benefits are also payable to correct 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 Benefits;

For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;

For marriage counseling;

For Custodial Care, domiciliary care or rest cures;

For equipment costs related to services performed on high cost technological equipment as defined by the Carrier, 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 Carrier;

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 booklet/certificate. Services not covered include, but are not limited to, 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 unless otherwise indicated;

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);

For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Appropriate/Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

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;

For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;

For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
For treatment of obesity, except for surgical treatment of morbid obesity when the Carrier (a) determines the surgery is Medically Appropriate/Medically Necessary, and (b) the surgery is not a repeat, reversal or revision of any previous obesity surgery. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person. This exclusion does not apply to nutrition visits as set forth in the Description of Benefits section under the subsection entitled "Nutrition Counseling for Weight Management";

For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

For weight reduction and premarital blood tests. This exclusion does not apply to nutrition visits as set forth in the Description of Benefits section under the subsection entitled "Nutrition Counseling for Weight Management";

For diagnostic screening examinations, except for mammograms and preventive care as provided in the "Primary and Preventive Care" section of the Description of Benefits;

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;

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;

For immunizations required for employment purposes, or for travel;

For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, Custodial Care in a Skilled Nursing Facility;

For counseling or consultation with a Covered Person’s relatives, or Hospital charges for a Covered Person’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 Benefits;

For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;

As described in the “Durable Medical Equipment” section in the Description of Benefits: for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the Covered Person’s condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

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

For prescription drugs, except as may be provided by a prescription drug rider attached to this booklet/certificate. 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 contraceptives;

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;
For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. 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 Benefits.

For Inpatient Private Duty Nursing services;

For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;

For Maintenance of chronic conditions;

For charges Incurred for expenses in excess of Benefit Maximums as specified in the Schedule of Benefits;

For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan’s limits, if any, shown on the Schedule of Benefits; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;

For Cognitive Rehabilitative 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 (e.g. stroke, acute brain insult, encephalopathy).

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;

For hearing aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription or fitting of hearing aids. Services and supplies related to these items are not covered;

For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);

For cranial prostheses, including wigs intended to replace hair;

For abortion services except when abortion is necessary to avert the death of the mother, and in cases when pregnancy is the result of rape or incest;

For any other service or treatment except as provided under this Plan.
A. BENEFITS TO WHICH YOU ARE ENTITLED

The liability of the Carrier is limited to the benefits specified in this booklet/certificate. The Carrier’s determination of the benefit provisions applicable for the services rendered to you (a Covered Person) shall be conclusive.

B. TERMINATION OF YOUR COVERAGE AND CONVERSION PRIVILEGE UNDER THIS PLAN

Termination of this Plan - Termination of the Group coverage (this Plan) automatically terminates all coverage for you (an Enrolled Employee) and your eligible Dependents. The privilege of conversion to a conversion contract shall be available to any Covered Person who has been continuously covered under the group contract for at least three (3) months (or covered for similar benefits under any group plan that this Plan replaced).

It is the responsibility of the Group to notify you and your eligible Dependents of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

If it is proven that you or your eligible Dependent obtained or attempted to obtain benefits or payment for benefits, through fraud or intentional misrepresentation, the Carrier, may, upon notice to you, terminate the coverage.

The privilege of conversion is available for you and your eligible Dependents except in the following circumstances:

1. The Group terminates this Plan in favor of group coverage by another organization; or
2. The Group terminates the Covered Person in anticipation of terminating this Plan 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 fifteen (15) days before or after the date of termination of this Plan, provided that if such notice is given more than fifteen (15) days but less than ninety (90) days after the date of termination of this Plan, the time allowed for the exercise of the privilege of conversion shall be extended for fifteen (15) days after the giving of such notice. Payment for coverage under the conversion contract must be made within thirty-one (31) days after the coverage under this Plan ends. Evidence of insurability is not required. Upon receipt of this payment, the conversion contract will be effective on the date of your termination under this Plan.

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

If your coverage or the coverage of your eligible dependent terminates because of your death, your change in employment status, divorce of dependent spouse, or change in a dependent’s eligibility status, the terminated Covered Person will be eligible to apply within thirty-one (31) days of termination (or termination of the continuation privileges under COBRA) to conversion coverage, of the type for which that person is then qualified at the rate then in effect. This conversion coverage may be different from the coverage provided under this Plan. Evidence of insurability is not required.
C. TERMINATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP IN THE GROUP

When a Covered Person ceases to be an eligible Employee or eligible Dependent, or the required contribution is not paid, the Covered Person’s coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Plan are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person’s termination under this Plan, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under this Plan to be not more than sixty (60) days before the first day of the month in which the Group notified the Carrier of such termination.

D. CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY

Your protection under this Plan may be extended after the date you cease to be a Covered Person because of termination of employment or membership in the Group. It will be extended if, on that date, you are 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 you remain Totally Disabled from any such illness or injury, but not beyond twelve (12) months if you cease to be a Covered Person because your coverage under this Plan ends.

Coverage under this Plan will apply during an extension as if you were still a Covered Person, except any reinstatement of your Lifetime Maximum amount will not be allowed under the “Reinstatement” subsection in the Schedule of Benefits. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you though the Carrier by the Group. Continuation of coverage is subject to payment of the applicable premium.

E. CONTINUATION OF INCAPACITATED CHILD

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you (an enrolled Employee) for over half of his support, you may apply to the Carrier to continue coverage of such child under this Plan upon such terms and conditions as the Carrier may determine. Coverage of such Dependent child shall terminate upon his or her 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 nineteen (19).

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining nineteen (19) 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 nineteen (19) years of age and joining the Carrier for the first time, the handicapped child must have been covered under the prior carrier and submit proof from the prior carrier that the child was covered as a handicapped person.

F. WHEN YOU TERMINATE EMPLOYMENT - CONTINUATION OF COVERAGE PROVISIONS CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED (COBRA)

This subsection, and the requirements of COBRA continuation, may or may not apply to the Group. You should contact your Employer to find out whether or not these continuation of coverage provisions apply.

For purposes of this subsection, a “qualified beneficiary” means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for benefits under this Plan as:

1. You, a covered Employee;
2. Your spouse; or
3. Your Dependent child.

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

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified beneficiary.
If An Employee Terminates Employment or Has a Reduction of Work Hours: If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to eighteen (18) months, if:

1. Your termination of employment was not due to gross misconduct; and
2. You are not entitled to Medicare.

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

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary’s health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within sixty (60) days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the eighteen (18) month continuation period described above for up to an extra eleven (11) months.

To elect the extra eleven (11) months of continuation, the plan administrator must be given written proof of Social Security’s determination of the qualified beneficiary’s disability before the earlier of:

1. The end of the eighteen (18) month continuation period; and
2. Sixty (60) days after the date the qualified beneficiary is determined to be disabled.

If, during the eleven (11) month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the plan administrator within thirty (30) days of such determination, and continuation will end, as explained in the “When Continuation Ends” paragraph of this subsection.

If an Employee Dies: If you (the covered Employee) die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months, subject to the “When Continuation Ends” paragraph of this subsection.

If an Employee’s Marriage Ends: If your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months, subject to the “When Continuation Ends” paragraph of this subsection.

If an Employee Becomes Entitled to Medicare: If you become entitled to Medicare after terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months from the date the initial eighteen (18) month continuation period started, subject to the “When Continuation Ends” paragraph of this subsection.

If you become entitled to Medicare before terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to eighteen (18) months, but may be extended until thirty-six (36) months from the date you became entitled to Medicare, subject to the “When Continuation Ends” paragraph of this subsection.

If a Dependent Loses Eligibility: If your Dependent child’s group health benefits end due to his or her loss of dependent eligibility as defined in this booklet/certificate, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to thirty-six (36) months, subject to the “When Continued Ends” paragraph of this subsection.
**Concurrent Continuations:** If your Dependent who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your Dependent may elect to extend his or her eighteen (18) month continuation period to up to thirty-six (36) months, if during the eighteen (18) month continuation period your Dependent becomes eligible for thirty-six (36) months of group health benefits due to any of the reasons stated above.

The thirty-six (36) month continuation period starts on the date the initial eighteen (18) month continuation period started, and the two (2) continuation periods will run concurrently.

**The Qualified Beneficiary's Responsibilities:** A person eligible for continuation under this subsection must notify the plan administrator, in writing, of:

1. Your divorce or legal separation from your spouse;
2. Your Dependent child’s loss of Dependent eligibility, as defined in this booklet/certificate; or
3. Social Security Administration’s determination of disability

The notice must be given to the plan administrator within sixty (60) days of either of these events.

In addition, a disabled qualified beneficiary must notify the plan administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the plan administrator within thirty (30) days of such final determination.

**The Employer's Responsibilities:** Your employer must notify the plan administrator, in writing, of:

1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your death;
3. Your entitlement to Medicare; or
4. Commencement of Employer’s bankruptcy proceedings.

The notice must be given to the plan administrator no later than thirty (30) days of any of these events.

**The Plan Administrator’s Responsibilities:** The plan administrator must notify the qualified beneficiary, in writing, of:

1. His or her right to continue the group health benefits described in this booklet/certificate;
2. The monthly premium he or she must pay to continue such benefits; and
3. The times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within fourteen (14) days of:

1. The date the employer notifies the plan administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
2. The date the qualified beneficiary notifies the plan administrator, in writing, of your divorce or legal separation from your spouse, or your Dependent child’s loss of eligibility.

**The Employer’s Liability:** Your employer will be liable for the qualified beneficiary’s continued group health benefits to the same extent as, and in the place of, the Carrier, if:

1. The plan administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above; or
2. The employer fails to remit a qualified beneficiary’s timely premium payment to the Plan on time, hereby causing the qualified beneficiary’s group health benefit to end.
Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the plan administrator written notice that he or she elects to continue benefits under the coverage. This must be done within sixty (60) days of the date a qualified beneficiary receives notice of his or her continuation rights from the plan administrator as described above or sixty (60) days of the date the qualified beneficiary’s group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month’s premium in a timely manner.

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

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional charge of two percent of the total premium charge may also be required by the employer.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra eleven (11) month continuation period.

If the qualified beneficiary fails to give the plan administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

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

When Continuation Ends: A qualified beneficiary’s continued group health benefits under this Plan ends on the first to occur of the following:

1. With respect to continuation upon your termination of employment or reduction of work hours, the end of the eighteen (18) month period which starts on the date the group health benefits would otherwise end;

2. With respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional eleven (11) months of continuation, the earlier of:
   a. The end of the twenty-nine (29) month period which starts on the date the group health benefits would otherwise end; or
   b. The first day of the month which coincides with or next follows the date which is thirty (30) days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;

3. With respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered Dependent’s eligibility, the end of the thirty-six (36) month period which starts on the date the group health benefits would otherwise end;

4. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
   a. After your termination of employment or reduction of work hours, the end of the thirty-six (36) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
   b. Before your termination of employment or reduction of work hours where, during the eighteen (18) month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the eighteen (18) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than thirty-six (36) months from the date you become entitled to Medicare.
5. The date coverage under this Plan ends;
6. The end of the period for which the last premium payment is made;
7. The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
8. The date he or she becomes entitled to Medicare.

THE CARRIER'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BOOKLET/CERTIFICATE.

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

G. RELEASE OF INFORMATION

Each Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Plan may furnish to the Carrier, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Carrier may furnish similar information to other entities providing similar benefits at their request.

The Carrier 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 Carrier needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Carrier 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 Covered Person.

H. CONSUMER RIGHTS

Each Covered Person 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 on your Identification Card.

I. LIMITATION OF ACTIONS

No legal action may be taken to recover benefits prior to sixty (60) days after notice of claim has been given as specified above, and no such action may be taken later than three (3) years after the date Covered Services are rendered.

J. CLAIM FORMS

The Carrier will furnish to the Covered Person or to the Group, for delivery to the Covered Person, such claim forms as are required for filing proof of loss for Covered Services provided by Non-Preferred Providers.
K. TIMELY FILING

The Carrier will not be liable under this Plan unless proper notice is furnished to the Carrier that Covered Services have been rendered to a Covered Person. Written notice must be given within twenty (20) days after completion of the Covered Services. The notice must include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Carrier 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 Carrier be required to accept notice more than two (2) years after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by Preferred Providers.

L. COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider is solely the Covered Person’s choice.
2. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by persons covered under this Plan. The Carrier is not liable for any act or omission of any Provider. The Carrier has no responsibility for a Provider’s failure or refusal to render Covered Services to a Covered Person.

M. SUBROGATION

In the event any service is provided or any payment is made to a Covered Person, the Carrier shall be subrogated and succeed to the Covered Person’s rights of recovery against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in your name. The Covered Person shall execute and deliver such instruments and take such other reasonable action as the Carrier may require to secure such rights. The Covered Person may do nothing to prejudice the rights given the Carrier without the Carrier's consent.

The Covered Person shall pay the Carrier all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Plan and as permitted by law.

The Carrier’s right of subrogation shall be unenforceable when prohibited by law.

N. COORDINATION OF BENEFITS

This Plan’s Coordination of Benefits (COB) provision is designed to conserve funds associated with health care. The following provisions do not apply to prescription drug coverage when provided through endorsement to this Plan.

1. Definitions

In addition to the Definitions of this Plan for purposes of is provision only:

"Plan" shall mean any group arrangement providing health care benefits or Covered Services through:

a. Individual, group, (except hospital indemnity plans of less than $200), blanket (except student accident) or franchise insurance coverage;
b. The Plan, health maintenance organization and other prepayment coverage;
c. Coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
d. Coverage under any tax supported or government program to the extent permitted by law.

2. 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 Plan, 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 Carrier and the other Plan in order to avoid duplication of benefits.
Benefits under this Plan will be provided in full when the Carrier is primary, that is, when the Carrier determines benefits first. If another Plan is primary, the Carrier will provide benefits as described below.

When an Employee has group health care coverage under this Plan and another Plan, the following will apply to determine which coverage is primary:

a. If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.

b. If the other Plan includes rules for coordinating benefits:
   (1) The Plan covering the patient other than as a Dependent shall be primary.
   (2) 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. However, if the other Plan does not have the birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child’s parents are separated or divorced.
   (3) Except as provided in subparagraph (4) below, if the child’s parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
      (i) First, the Plan covering the child as a Dependent of the parent with custody;
      (ii) Then, the Plan of the spouse of the parent with custody of the child;
      (iii) Finally, the Plan of the parent not having custody of the child.
   (4) 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.
   (5) 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 2.b.(2).

c. 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.

d. If none of the above rules apply, the Plan which covered the Employee longer shall be primary.

3. **Effect on Benefits**

When the Carrier’s Plan is secondary, the benefits under this Plan will be reduced so that the Carrier will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Plan 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 Carrier payment exceed the amount that would have been payable under this Plan if the Carrier 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, Preferred Provider arrangements and other cost-sharing features.

Certain facts are needed to apply COB. The Carrier has the right to decide which facts are needed. The Carrier 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 Carrier deems necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Carrier such information as may be necessary to implement this provision. The Carrier, 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 Plan shall be affected by the benefits that would be payable under any and all other Plans only to the extent that the Carrier is furnished with information relative to such other Plans.

Right of Recovery

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, the Carrier 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 Plan and, to the extent of such payments, the Carrier shall be fully discharged from liability under this Plan.

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

1. The person the Carrier has paid or for whom they have paid;
2. Insurance companies; or
3. Any other organizations.

You, on your own behalf and on behalf of your 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 Carrier.

O. 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 coverage (e.g., obtaining Precertification, use of Preferred, Participating or Member Providers), or to the administration of this benefit program by the Carrier, the Carrier may on a selective basis, waive certain procedural requirements of this coverage. 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 Carrier 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 Carrier nor the Providers in the Carrier’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 Carrier and appropriate regulatory authority, are extraordinary circumstances not within the control of the Carrier, including but not limited to: (a) major disaster; (b) epidemic; (c) pandemic; (d) the complete or partial destruction of facilities; (e) riot; or (f) civil insurrection.
A. UTILIZATION REVIEW PROCESS

A basic condition of IBC’s, and its subsidiary QCC Insurance Company’s (“the Carrier”) benefit plan coverage is that in order for a health care service to be covered or payable, the services must be Medically Appropriate/Medically Necessary. To assist the Carrier in making coverage determinations for requested health care services, the Carrier uses established IBC Medical Policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/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 Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person’s benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by the Carrier to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/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 Carrier based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. 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 Carrier 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 Appropriateness/Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval using the Carrier’s Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Carrier may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/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 Covered Person’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 Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and Covered Person in accordance with applicable law.

The Carrier’s utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to the Carrier’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 Carrier 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.
B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

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

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Carrier in determining Medical Appropriateness/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 Appropriateness/Medical Necessity of coverage based on a Covered Person’s specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Carrier’s plan determinations for similar medical issues and requests, and reduces practice variation among the Carrier’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 (e.g., hysterectomy and sinus surgery).
- Inpatient hospitalizations
- Inpatient Rehabilitation
- Home Health
- Durable Medical Equipment
- Skilled Nursing Facility


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 Policies 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.

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

The Carrier delegates its utilization review process to the Carrier’s affiliate, Independence Healthcare Management (“IHM”). IHM is a state licensed utilization review entity and is responsible for the Carrier’s utilization review process. In certain instances, the Carrier has delegated certain utilization review activities, including Pre-certification 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/substance 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 Carrier’s approval.
Utilization Review and Criteria for Mental Health/Substance Abuse Services

Utilization Review activities for mental health/substance abuse services have been delegated by IBC (and QCC) to a behavioral health management company, which administers the mental health and substance abuse benefits for the majority of the Carrier’s Covered Persons.

D. PRECERTIFICATION REVIEW

When required, Precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Covered Person’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 Covered Person depending on whether the Provider is a Personal Choice Network Provider. For Covered Person’s located outside the Carrier’s Personal Choice Network who are accessing BlueCard Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Precertification review. Where Precertification review is required, the Carrier’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 Appropriateness of the requested procedure setting (e.g., Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Appropriateness/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 Carrier’s local Preferred or Participating Provider does not require such review. The following are general examples of current Precertification review requirements under benefit plans; however, these requirements vary by benefit plan and state and are subject to change.

- Hysterectomy
- Nasal surgery procedures
- Bariatric surgery
- Potentially cosmetic or experimental/investigative procedures

The following information provides more specific information of this benefit plan’s Precertification requirements.

1. INPATIENT PRE-ADMISSION REVIEW

Preferred 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 Carrier as to the Medical Appropriateness/Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the “Emergency Admission Review” subsection of this Managed Care section. A Preferred Hospital, Skilled Nursing Facility, or other Facility Provider in the Personal Choice Network will verify the Precertification at or before the time of admission. However, the Covered Person, not the Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard PPO Program. The Carrier will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if Precertification is required and is not obtained in advance. For Covered Person’s who reside in the Carrier’s local Personal Choice Network service area, the Carrier will hold the Covered Person harmless and the Covered Person 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: (a) the Provider provides prior written notice that the admission will not be paid by the Carrier; and (b) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Facility Provider admission.

**Non-Preferred Inpatient Admissions**

For a Non-Preferred Inpatient Admission and an Inpatient Admission to a BlueCard PPO Provider, the Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Precertification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact the Carrier prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Carrier will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Non-Preferred level shown in the *Schedule of Benefits* if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet/certificate.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the amount, as shown in the *Schedule of Benefits*, will be deemed not to be Covered Services under this coverage. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person’s obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

If a Covered Person 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 Covered Person will be financially liable for non-covered Inpatient charges.

c. If Precertification is denied, the Covered Person, 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 Covered Person, Physician, or Facility Provider will be so notified.

2. **EMERGENCY ADMISSION REVIEW**

a. **Preferred Admissions**

It is the responsibility of the Preferred Provider to notify the Carrier of the In-Network Emergency admission.

b. **Non-Preferred and BlueCard Provider Admissions**

1. Covered Persons are responsible for notifying the Carrier of a Non-Preferred or BlueCard Provider Emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Carrier.

2. Failure to initiate Emergency admission review will result in a reduction in Covered Expense for Non-Preferred services. Such penalty, as shown in the *Schedule of Benefits*, will be the sole responsibility of, and payable by, the Covered Person.

3. If the Covered Person elects to remain hospitalized after the Carrier and the attending Physician have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.
3. **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 Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person 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 Carrier not being notified of a Covered Person’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 Carrier also may determine coverage of certain procedures and other benefits available to Covered Persons through prenotification as required by the Covered Person’s benefit plan, and discharge planning.

**Pre-notification.** Pre-notification is advance notification to the Carrier of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons 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 Covered Person’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 Carrier’s authorization of covered post-Hospital services and identifying and referring Covered Persons to disease management or case management benefits.

**Selective Medical Review.** In addition to the foregoing requirements, the Carrier 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 Carrier reserves the right to waive medical review for certain Covered Services for certain Providers, if the Carrier 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 Covered Persons where required Selective Medical Review is not obtained by the Provider.

E. **OTHER PRECERTIFICATION REQUIREMENTS**

Precertification is required by the Carrier in advance for Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Outpatient treatment (including Partial Hospitalization services) of Alcohol and Drug Abuse, Mental Health/Psychiatric Care and Serious Mental Illness. A complete list of Precertification requirements is shown in the “Services Requiring Precertification” subsection of this Managed Care section. When a Covered Person plans to receive any of these listed procedures, the Carrier will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed in the “Services Requiring Precertification” subsection of this Managed Care section, that are performed during an Emergency, as determined by the Carrier, do not require Precertification. However, the Carrier should be notified within two (2) business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Carrier.
1. **Preferred Care**

   Preferred Providers in the Personal Choice Network must contact the Carrier to initiate Precertification. The Carrier will verify the results of the Precertification with the Covered Person and with the Preferred Provider. If the Preferred Provider is a BlueCard PPO Provider, however, the Covered Person must initiate Precertification.

   If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the “Services Requiring Precertification” subsection of this Managed Care section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, subject to a Penalty.

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

2. **Non-Preferred Care**

   For Non-Preferred Care and care provided by BlueCard Providers, the Covered Person is responsible to have the Provider performing the service contact the Carrier to initiate Precertification. The Carrier will verify the results of the Precertification with the Covered Person and the Provider.

   If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the “Services Requiring Precertification” subsection of this Managed Care section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but the Provider’s charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty, as shown in the Schedule of Benefits. Such Penalty, and any difference in what is covered by the Carrier and the Covered Person’s obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

**F. SERVICES REQUIRING PRECERTIFICATION**

The following services must be Precertified whether Preferred (In-Network) or Non-Preferred (Out of Network), unless otherwise noted.

1. **ALL INPATIENT ADMISSIONS**
   a. Acute Rehabilitation
   b. Alcohol and Drug Abuse and Dependency
   c. Inpatient Hospice
   d. Maternity (notification only)
   e. Mental Health/Psychiatric Care, Serious Mental Illness
   f. Skilled Nursing Facility
   g. Home Health Care

2. **OUTPATIENT SERVICES**
   a. Alcohol and Drug Abuse and Dependency (including Partial Hospitalization services)
   b. Ambulance Services – non-Emergency
   c. Birth Center (notification only)
   d. Day Rehabilitation Program
   e. Dental Services as a Result of Accidental Injury
   f. Durable Medical Equipment (items over $500 billed amount, including repairs and replacements, and all rentals). This Precertification requirement does not apply to oxygen, diabetic supplies and unit dose medication for nebulizers.
   g. Home Health Care
   h. Mental Health/Psychiatric Care, Serious Mental Illness (including Partial Hospitalization services)
i. Comprehensive Pain Management Programs (including epidural injections)
j. Private Duty Nursing
k. Orthotics and Prosthetics (items over $500 billed amount, including repairs and replacements).
   This Precertification requirement does not apply to ostomy supplies.
l. Sleep Studies

3. **DIAGNOSTIC SERVICES**
   a. CT/CTA Scans
   b. MRI/MRA
   c. Nuclear Cardiology Imaging
   d. PET Scans

4. **SURGICAL PROCEDURES** (regardless of place of service)
   a. Cataract Surgery
   b. Hysterectomy
   c. Nasal Surgery for submucous resection and septoplasty
   d. Obesity Surgery
   e. Transplants (except cornea)
   f. Uvulopalatopharyngoplasty (including laser-assisted)

5. **SURGICAL/RECONSTRUCTIVE PROCEDURES**
   a. Abdominoplasty
   b. Augmentation mammoplasty
   c. Blepharoplasty
   d. Chemical Peels and Dermabrasion
   e. Excision of redundant skin
   f. Keloid Removal
   g. Lpectomy/Liposuction
   h. Mastopexy
   i. Orthognathic surgery procedures
   j. Otoplasty
   k. Panniculectomy
   l. Reduction Mammaplasty
   m. Removal or Reinsertion of breast implants
   n. Rhinoplasty
   o. Scar Revision
   p. Subcutaneous Mastectomy for Gynecomastia
   q. Surgery for varicose veins

6. **INFUSION THERAPY**
   1. Infusion Therapy in a home setting
   2. Drugs listed below that are given by Infusion Therapy when such Infusion Therapy is provided in an
      Outpatient Facility or in a Professional Provider’s office.

      *Aldurazyme, Aredia, Avastin, Boniva, Ceredase, Cerezyme, Elaprase, Erbitux, Fabrazyme,
      Genasense, Herceptin, IVIG, Myozyme, Ocrecia, Remicade, Respigam, Tysabri

   *Infusion drugs that are newly approved by the FDA during the effective term of the Group Contract are
   considered new and emerging technology and will be subject to Precertification, pending notification by
   the Carrier. No penalty associated with failure to obtain Precertification approval for any drug not found on
   the list above, will be applicable to a Covered Person until such time as the Group Contract and
   booklet/certificate form are amended accordingly.

THE ABOVE LIST OF PRECERTIFICATION REQUIREMENTS IS SUBJECT
TO CHANGE ANNUALLY. PRIOR NOTIFICATION WILL BE PROVIDED.
7. **BIOTECH/SPECIALTY INJECTABLE DRUGS** (see list under “Biotech/Specialty Injectables” in *Description of Benefits*)

**THIS LIST OF BIOTECH/SPECIALTY MEDICATION PRECERTIFICATION REQUIREMENTS IS SUBJECT TO CHANGE AS NEW INJECTABLE MEDICATIONS COME TO MARKET. PRIOR NOTIFICATION WILL BE PROVIDED**

In addition to the Precertification requirements listed above, the Covered Person should contact the Carrier for certain categories of treatment (listed below) so that the Covered Person will know prior to receiving treatment whether it is a Covered Service. This applies to Preferred Providers in the Preferred Provider Organization network and to Covered Persons (and their Providers) who elect to receive treatment provided by either BlueCard Providers or Non-Preferred (Out-of-Network) Providers. Those categories of treatment (in any setting) include:

1. Any surgical procedure that may be considered potentially cosmetic;
2. Any procedure, treatment, drug or device that represents “emerging technology”, and
3. Services that might be considered Experimental/Investigative.

The Carrier encourages the Covered Person’s Provider to place the call for the Covered Person.

For more information, please see the *Notices* placed in the front pages of this booklet/certificate that pertain to Experimental/Investigative services, Cosmetic services, Medically Appropriate/Medically Necessary services and Emerging Technology.

**G. DISEASE MANAGEMENT AND DECISION SUPPORT PROGRAMS**

Disease Management and Decision Support programs help Covered Persons to be effective partners in their health care by providing information and support to Covered Persons with certain chronic conditions as well as those with everyday health concerns. Disease Management is a systematic, population-based approach that involves identifying Covered Persons 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 Covered Persons 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 Covered Persons manage their chronic condition in partnership with their Physician(s). Disease Management programs, when successful, can help such Covered Persons 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 Covered Persons 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 Carrier will utilize medical information such as claims data to operate the Disease Management or Decision Support program, e.g. to identify Covered Persons with chronic disease, to predict which Covered Persons would most likely benefit from these services, and to communicate results to Covered Person’s treating Physician(s). The Carrier will decide what chronic conditions are included in the Disease Management or Decision Support program.

Participation by a Covered Person in Disease Management or Decision Support programs is voluntary. A Covered Person may continue in the Disease Management or Decision Support program until any of the following occurs: 1. the Covered Person notifies the Carrier that he/she declines participation; or 2. the Carrier determines that the program, or aspects of the program, will not continue.
H.  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 Non-Preferred care at the Preferred level of benefits. Charges for treatment will be paid at the Preferred level of benefits when the Dependent student receives care from Providers as described in the "BlueCard PPO Program" subsection of the Your Personal Choice Network Plan section. However, treatment provided by an educational facility's infirmary for Urgent Care, for example, may also be paid at the Preferred level of benefits, but the Carrier should be notified within forty-eight (48) hours of treatment to insure Covered Services are treated as Preferred 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 Plan.
For purposes of this section only, the term “Member” replaces the term “Covered Person.”

MEMBER COMPLAINT PROCESS

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

General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

MEMBER APPEAL PROCESS

Filing an Appeal. The Carrier maintains procedures for the resolution of Member Appeals. Member Appeals may be filed within one hundred eighty (180) days of the receipt of a decision from the Carrier 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 Carrier 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 Carrier 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 Carrier, 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 Applicable Timeframes. Following are the two types of Member Appeals and the issues they address:

- **Medical Necessity Appeal** – An Appeal by or on behalf of a Member that focuses on issues of Medical Appropriateness/Medical Necessity and requests the Carrier 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** – An Appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Carrier 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 Appropriateness/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 Appeal timeframes apply to both pre-service Appeals and post-service Appeals that concern claims for non-urgent care.

- **Pre-service Appeal** - An Appeal for benefits that, under the terms of the Plan, must be Precertified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available. A maximum of fifteen (15) days is available for each of the two (2) levels of internal review available for a standard Pre-service Appeal.

- **Post-service Appeal** - An Appeal for benefits that is not a Pre-service Appeal. (Post-service Appeals concerning claims for services that the Member has already obtained do not qualify for review as Expedited/Urgent Appeals.) A maximum of thirty (30) days is available for each of the two (2) levels of internal review available for a standard Post-service Appeal.

Expedited Appeal timeframes apply to pre-service requests for Urgent Care.

- **Expedited/Urgent appeal** – An Appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Carrier 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. A maximum of seventy-two (72) hours is available for internal review of an Expedited Appeal.

**Information for the Appeal Review including Matched Specialist’s Report.** At all Appeal levels the Member may submit to the Carrier additional information pertaining to his case. The Member may specify the remedy or action being sought. Upon request at any time during the Appeal process, the Carrier will provide the Member or his authorized representative access to, and copies of all relevant documents and records, including information reviewed by the decision maker(s) on the Appeal.

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 employees of the Carrier who have been designated 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 his authorized representative or obtained from other sources during the investigation of the Appeal issues.

**Right to Pursue Civil Action.** If the Member is enrolled in a group health plan that is subject to the requirements of Employee Retirement Income Security Act of 1974 (ERISA), he has the right to bring a civil action under Section 502(a) of the Act after completing the Member Appeal processes described here.

**Changes in Member Appeals Processes.** Please note that the Member Appeal processes described here may change due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve the Member Appeals processes, or to reflect decisions of the Group regarding the administration of Member Appeal processes for this Plan.
INTERNAL STANDARD AND EXPEDITED APPEALS

There are two levels of internal standard Appeal and one level of internal expedited Appeal.

Level One Standard Appeal

An acknowledgement letter and description of the Appeal process is mailed within five (5) business days of receipt of a Member Appeal. The initial request for an Appeal will be evaluated and the decision completed within the following timeframes for a standard Appeal on an Administrative or Medical Necessity Appeal issue:

- Standard Pre-service Appeal – within fifteen (15) days of receipt of the Appeal request
- Standard Post-service Appeal – within thirty (30) days of receipt of the Appeal request

The Member will be sent written notice of the first level decision within the timeframe stated above that applies to the Appeal. If the Member’s 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, and describe how he can Appeal to the next level. The first level Appeal decision for a Standard Appeal is final unless the Member exercises his right to appeal the decision as described below.

Level Two Standard Appeal

If the Member is not satisfied with the first level decision, he may request a second level Appeal within sixty (60) days. The Appeal will be evaluated and the decision completed within the following timeframes for the second level review of a Standard Appeal on an Administrative or Medical Necessity Appeal issue:

- Standard Pre-service Appeal – within fifteen (15) days of receipt of the Appeal request
- Standard Post-service Appeal – within thirty (30) days of receipt of the Appeal request

The Member or his authorized representative has the right to present the Member’s Appeal to the Second Level Appeal Committee in person or via conference call. The Second Level Appeal Committee meeting is a forum where Members each have an equal amount of time to present their issues in an informal setting that is not open to the public. Two (2) other people may accompany the Member, unless the Member receives prior approval from the Carrier for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member’s representative. Members may not audiotape, videotape, or transcribe the committee proceedings. The Carrier will contact the Member to schedule the Committee meeting for his Standard Appeal. The Appeal review may also occur based on the Appeal record without the Member’s participation if he does not want to participate or repeated attempts to schedule the Member’s participation fail.

Written notice of the second level decision will be sent within the timeframes stated above. If the Member’s 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, and tell the Member what relevant information is available.

The second level decision is final with respect to the Member’s right to review of an Administrative Appeal through the Carrier’s Member Appeal process. Additional Appeal rights for review of Medical Necessity Appeals are described below under “External Standard and Expedited Medical Necessity Appeals.”

Expedited Appeals

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

- Expedited Pre-service Appeals - within seventy-two (72) hours of receipt of the Appeal request.
To request an Expedited Appeal by the Carrier, the Member should call Member Services at the toll free telephone number listed on the back of his Identification Card, or call, or fax the Member Appeals Department at the phone numbers listed above. Information related to the Member’s Appeal will be requested and he will be promptly informed whether it qualifies for review as an Expedited Appeal or must instead be processed as a Standard Appeal. The Committee will also review all relevant information for the Appeal from the Member or his authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an Expedited Appeal.

A Member has the right to present his Appeal to the Committee in person or via conference call. The Expedited Appeal Committee meeting is a forum where Members each have an equal amount of time to present their issues in an informal setting that is not open to the public. Two (2) other people may accompany the Member unless he receives prior approval for additional assistance due to special circumstances. Members of the press may only attend in their personal capacity as a Member’s representative. Members may not audiotape, videotape, or transcribe the committee proceedings. While efforts will be made to accommodate the participants requested by the Member or his authorized representative, Expedited Appeals must adhere to the established time limits.

The Expedited Appeal review will be completed promptly based on the Member’s health condition, but no later than seventy-two (72) hours after receipt of his Expedited Appeal by the Carrier. The Member will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. The Expedited Appeal decision is then final with respect to a Member’s right to review of an Administrative Appeal through the Carrier’s Member Appeal process. Additional Appeal rights for review of Medical Necessity Appeals are described below under “External Standard and Expedited Medical Necessity Appeals.”

EXTERNAL STANDARD AND EXPEDITED MEDICAL NECESSITY APPEALS

If the Member is not satisfied with the decision of the internal Second Level Medical Necessity Appeal Committee or Expedited Medical Necessity Appeal Committee, he may file an external appeal—standard or Expedited—as described below. Both types of external Medical Necessity Appeals are submitted to Independent Review Organizations (IROs). When the Carrier, assigns an IRO to an external Medical Necessity Appeal, the decision is rendered at no cost to the Member involved in the external Medical Necessity Appeal. If the IRO decides that the care or services requested in the external Medical Necessity are Covered Services that are Medically Necessary, then the IRO notifies the Member or his authorized representative in writing that the prior Appeal decision is overturned and the Carrier follows-up by arranging for service approval or claim payment as appropriate.

External Standard Medical Necessity Appeal:

The Member or his authorized representative may request an external Medical Necessity Appeal review by an IRO by calling or writing to the Carrier within one hundred and eighty (180) calendar days of receipt of the internal Appeal decision letter. The Member or his authorized representative may also request an external Appeal review at any time during the internal Appeals process if the Carrier exceeds the time limit for making a decision. To request an external Medical Necessity Appeal review by an IRO, call or write to the Member Appeals Department at the phone number or address listed above under the section entitled “Member Appeal Process – Filing an Appeal.” The Carrier will acknowledge receipt of the Member’s external standard Grievance Appeal in writing. (If the Carrier overturns the prior decision at any time while his external Appeal is pending due to receipt of additional information, the IRO is notified and, with the Member’s permission, the external review is ended.) The Member and his authorized representative are not required to pay any of the costs associated with the external review.

The Member is sent written confirmation of receipt of his external Medical Necessity review request from the Carrier within five (5) business days of receipt of the request. This confirmation includes the name and contact information for the Carrier staff person assigned to facilitate the processing of the Member’s Appeal and information on the IRO assignment. Information on the IRO assignment identifies the assigned IRO by name and states the board certification and/or specialty of the physician or psychologist that the IRO appoints to review the Member’s Appeal.
Whenever possible, the IRO assigned to the external Appeal request, is a different organization than the one that supplied the same/or similar specialty review for the internal Appeal process. The Physician or psychologist appointed by the IRO to review the Member’s external Appeal, has not been previously involved in any aspect of decision-making on the Appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Carrier, with the Member, or his authorized representative. The Carrier’s arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Carrier assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal Appeal process, nor a subordinate of that person. If the Member feels that a conflict exists, he should call or write the contact person listed on the acknowledgement letter from the Carrier no later than two (2) business days from receipt of the acknowledgment letter from the Carrier.

Within fifteen (15) calendar days of receipt of the Member’s request, the Carrier sends the Member, his authorized representative, and the IRO a letter listing all documents forwarded to the IRO. These documents include copies of all information submitted for the internal Appeal process, as well as any additional information that the Member, his authorized representative, or the Carrier may submit. If the Member wishes to submit additional information for consideration by the IRO, he should do so within ten (10) calendar days of the Member’s request for an external Appeal.

The Carrier does not interfere with the IRO’s proceedings or Appeals decisions. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal Appeal process.

The IRO makes its final decision within thirty (30) calendar days of receipt of the Member’s request by the Carrier and simultaneously issues its decision in writing to the Member or his authorized representative and to the Carrier. The established deadline for a decision from the IRO may only be exceeded for good cause when a reasonable delay for a specific period is acceptable to the Member or his authorized representative. If the decision of the IRO is that the services are Medically Appropriate/Medically Necessary, the Carrier authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment or approval of the service in the event of an overturn of the Member’s Appeal. The Carrier implements the IRO’s decision within the time period, if any, specified by the IRO.

The external decision is binding on the Carrier.

**External Expedited Medical Necessity Appeal**

The Member or his authorized representative may request an external expedited third level Medical Necessity review if the Member’s case involves a serious medical condition which the Member believes may jeopardize his life, health, ability to regain maximum function, or would subject him to severe pain that cannot be adequately managed while awaiting a standard decision. This request can be made after the Member has completed the internal process or if the Carrier exceeds the time limit for making a decision. To request an external expedited Medical Necessity review by an IRO, the Member should call or write to the Member Appeals Department at the phone number or address listed above under the section entitled “Member Appeal Process – Filing an Appeal.”

If the Carrier overturns the prior decision at any time while the Member’s external Appeal is pending due to receipt of additional information, the IRO is notified, and with the Member’s permission, the external review is ended.

The Member and his authorized representative are not required to pay any of the costs associated with the external review.

Within twenty-four (24) hours of receipt of the Member’s request for an expedited Appeal, the Carrier confirms his request is for an external expedited Medical Necessity Appeal and faxes his request to the assigned IRO. During this time, the Carrier also forwards to the IRO, by secure electronic transmission or overnight delivery, all information submitted in the internal Appeal process and any additional information that the Member, his authorized representative, or the Carrier wishes to submit to the IRO.
Whenever possible, the IRO assigned to the external expedited Appeal is a different organization than the one that supplied the matched specialist for the internal Appeal process. The Physician or psychologist appointed by the IRO to review the Member’s external Appeal has not been previously involved in any aspect of decision-making on the Appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Carrier, with the Member, or with his authorized representative. The Carrier’s arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Carrier assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal Appeal process, nor a subordinate of that person. If the Member feels that a conflict exists, the Member should immediately contact the person listed on the acknowledgement letter from the Carrier.

The Carrier does not interfere with the IRO’s proceedings or Appeals decisions. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal Appeal process.

The IRO makes a decision and simultaneously notifies the Member or his authorized representative and the Carrier in writing within forty-eight (48) hours of receipt of all relevant documentation. The decision letter identifies the assigned IRO by name and states the board certification and/or specialty of the Physician or psychologist that the IRO appoints to review the external Appeal.

The time period for issuing the final decision on the expedited Medical Necessity Appeal can be extended for five (5) calendar days for good cause when such a delay is acceptable to the Member or his authorized representative.

If the decision of the IRO is that the services are Medically Appropriate/Medically Necessary, the Carrier authorizes the service and/or pays the claims. The Member is notified in writing of the time and procedure for claim payment and/or approval of the service in the event of an overturn of his Appeal. The Carrier implements the IRO’s decision within the time period, if any, specified by the IRO.

The external decision is binding on the Carrier.
Supplemental Benefits
Vision Benefits Program

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 Carrier")

ACCOUNT NAME
(Hereafter called "The Contractholder")

VISION CARE PROGRAM
QCC Insurance Company
(Hereafter called "the Carrier")

GROUP HEALTH BENEFITS BOOKLET/CERTIFICATE

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

This Booklet/Certificate replaces any and all Booklet/Certificates previously issued by the Carrier providing the types of benefits described in this Booklet/Certificate.

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

By: __________________________
    R. Scott Post
    Vice President, Marketing Administration
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</tbody>
</table>
SECTION 1 - DEFINED TERMS

For the purposes of this Booklet/Certificate, the terms below have the following meaning:

ACCREDITED EDUCATIONAL INSTITUTION – a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) 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 Carrier. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

BILLED CHARGE - an amount billed by a Supplier or Professional Provider for treatment, services or supplies rendered to a Covered Person.

COINSURANCE - a specific percentage of the Provider’s Reasonable Charge for Covered Services set forth in the section entitled SCHEDULE OF BENEFITS, for which the Covered Person is responsible.

A. Program Coinsurance - a specified percentage of the Provider’s Reasonable Charge applied to all Covered Services for which the Covered Person is responsible.

B. Benefit Coinsurance - a specified percentage of the Provider’s Reasonable Charge applied to a specific Covered Service for which the Covered Person is responsible.

CONTRACT - the Group Policy of Vision Care Benefits, including the Group Application, riders and/or endorsements, if any, between the Carrier and the Group, also referred to as the Group Contract.

CONTRACTHOLDER - any individual, corporation or other entity who, as the representative of an enrolled group of Employees (Members) and as Agent for the Members is acceptable to the Carrier. The Contractholder has agreed to pay the charges payable under the Contract to the Carrier and to receive any information from the Carrier on behalf of the Applicants.

COPAYMENT - a specified amount of expenses applied to a specific Covered Service for which the Covered Person is responsible per Covered Service.

COVERED PERSON - an enrolled Employee or Member and his or her Eligible Dependents who have satisfied the specifications under the section entitled WHO IS COVERED section of this Booklet-Certificate.

COVERED SERVICE - a service or supply specified in this Booklet/Certificate for which benefits will be provided when rendered by a Professional Provider or Supplier. For purposes of this coverage, the term “Covered Materials” means Covered Services, with the exception of Eye Examination and Refractive Services.

DEPENDENT - a Covered Person other than the Employee or Member as specified in the section entitled Who is Covered.

EFFECTIVE DATE - a date on which coverage for a Covered Person begins under the Group Contract.

EMPLOYEE/MEMBER - an individual in the Group who meets the eligibility requirements for enrollment who is so specified for enrollment and in whose name the identification card is issued.
**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 Paragraph "A" of the section entitled **VISION CARE BENEFITS**.

**FAMILY COVERAGE** - coverage for the Member and one or more of the Member’s Dependents or Member’s Dependents.

**INCURRED** - a charge shall be considered Incurred on the date a Covered Person 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 (3) distinct areas for visual focus.

**LIMITATIONS** - the Maximum frequency or age set forth in “Section 3 - SCHEDULE OF BENEFITS,” for which a Covered Service is allowed.

**MAXIMUM** - the greatest amount payable by the Carrier 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.

- **A. Program Maximum** - the greatest amount payable by the Carrier for Covered Services.

- **B. Benefit Maximum** - the greatest amount payable by the Carrier for a specific Covered Service.

**NON-PARTICIPATING PROVIDER** - a Provider that does not participate in the Carrier’s programs and is not required to accept the Carrier’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 who may perform Eye Examination and Refractive Services.
**PARTICIPATING PROVIDER** - a Provider that has an agreement with the Carrier 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 of its branches, perform surgery and dispense drugs.

**PROFESSIONAL PROVIDER** - a person or practitioner licensed where required and performing within the scope of such license. The Professional Providers include:

- Doctor of Ophthalmology
- Doctor of Optometry
- Doctor of Medicine
- Doctor of Osteopathy
- Physician

**PROVIDER’S REASONABLE CHARGE** - the dollar amount on which a Covered Person’s Coinsurance, Benefit Maximums and benefits will be calculated. "Provider’s Reasonable Charge" shall mean the following:

i. 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;

ii. For services rendered by a Non-Participating Provider, "Provider’s Reasonable Charge" means the Reasonable and Customary Charges, or Benefit Maximum 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 Carrier. 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 Carrier determines what is reasonable by the severity and/or complexity of the Covered Person’s condition for which the service or supply is provided.

**SUPPLIER** - a provider engaged in dispensing ophthalmic material (e.g., contact lenses, spectacle lenses) in accordance with a prescription written by a Professional Provider. Suppliers include, but are not limited to, Opticians and retail optical dispensing firms.

**TOTAL DISABILITY** - except as otherwise specified in this Booklet-Certificate, a Member who, due to illness or injury, cannot perform any duty of his or her occupation or any occupation for which he or she 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 he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Member or Dependent must be under the regular care of a Physician.
SECTION 2 - WHO IS COVERED

ELIGIBLE PERSON

Eligible Person is defined as:

1. a Member who is determined by the Group as eligible to apply for coverage and sign the Application; and

2. Eligible Dependents as specified to the Carrier by the Group as eligible for coverage.

ELIGIBLE DEPENDENT:

Eligible Dependent is defined as:

1. the Member’s spouse under a legally valid existing marriage between persons of the opposite sex.

2. 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 Contract. For information concerning the limiting age for covered, unmarried children, please refer to the “Eligibility Under The Plan” section of the booklet located under the “Your Benefits” section.

3. A full-time student who is eligible for coverage under the coverage who is (1) 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 (2) 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 Carrier approved by the Department of Military & Veterans Affairs (DMVA): (1) notifying the Carrier that the Dependent has been placed on active duty; (2) notifying the Carrier that the Dependent is no longer on active duty; (3) 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.

4. 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 Contract. The Carrier may require proof of such Member’s eligibility from time to time.

5. 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 Contract Date, that date becomes the Effective Date.
SECTION 3 - SCHEDULE OF BENEFITS

VISION CARE BENEFITS

Subject to the Exclusions, conditions and Limitations of this Booklet/Certificate, a Covered Person is entitled to benefits for Covered Services described in this section during a Benefit Period, subject to the Deductible, if any, and in the amounts as specified in this Schedule of Benefits Section.

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Two (2) Calendar Years</th>
</tr>
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<tbody>
<tr>
<td>Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Benefit Period Maximum</td>
<td>$100 for all Covered Services and (Participating or Non-Participating) Supplies; except eye examination services are not included in this Benefit Period Maximum.</td>
</tr>
</tbody>
</table>
**SCHEDULE OF COVERED SERVICES**

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>AMOUNTS PAYABLE AND LIMITATIONS ON COVERED SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating*</td>
</tr>
<tr>
<td>Eye examination, including refraction and glaucoma screening and dilation, as</td>
<td>100% of the Provider’s Reasonable Charge.</td>
</tr>
<tr>
<td>professionally indicated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Participating</td>
</tr>
<tr>
<td>Eye examination, including refraction and glaucoma screening and dilation, as</td>
<td>100% of the Provider’s Reasonable Charge, up to</td>
</tr>
<tr>
<td>professionally indicated.</td>
<td>a Maximum of $35</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Eyeglasses, including Spectacle Lenses and Frames (one pair)</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Spectacle Lenses</td>
<td></td>
</tr>
<tr>
<td>• All ranges of prescriptions, oversize lenses, glass or plastic, single vision,</td>
<td>100%</td>
</tr>
<tr>
<td>bifocal, trifocal or lenticular lenses.</td>
<td></td>
</tr>
<tr>
<td>• Polycarbonate lenses for dependent children and monocular patients and patients</td>
<td>100%</td>
</tr>
<tr>
<td>with prescriptions greater than or equal to +/- 6.00 diopters</td>
<td></td>
</tr>
<tr>
<td>• Glass grey #3 prescription sunglass lenses</td>
<td>100%</td>
</tr>
<tr>
<td>• Tinting</td>
<td>100%</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
</tr>
<tr>
<td>- Plan supplied:</td>
<td></td>
</tr>
<tr>
<td>• Fashion selection</td>
<td>100%</td>
</tr>
<tr>
<td>• Designer selection</td>
<td>100%</td>
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<tr>
<td>• Premier selection</td>
<td>100%</td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>- Doctor Supplied</td>
<td>Up to a Maximum of $65 towards purchase</td>
</tr>
<tr>
<td>Contact Lenses (in lieu of eyeglasses), including Standard, Specialty and</td>
<td>100%, up to a Maximum of $100</td>
</tr>
<tr>
<td>Disposable Lenses and Evaluation and Fitting</td>
<td></td>
</tr>
<tr>
<td>*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Carrier reserves the right to modify the</td>
</tr>
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<td></td>
<td>Schedule of Covered Services from time to time,</td>
</tr>
<tr>
<td></td>
<td>subject to prior notice to the Group.</td>
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</table>

* The Carrier reserves the right to modify the Schedule of Covered Services from time to time, subject to prior notice to the Group.
SECTION 4 - VISION CARE BENEFITS

COVERED SERVICES

Subject to the Exclusions, conditions, and Limitations set forth in this Booklet/Certificate, a Covered Person is entitled to the benefits of this benefit section for Covered Services rendered by a Professional Provider or Supplier, unless otherwise indicated, in the amounts specified in the Schedule of Benefits.

This program allows you to maximize your Vision Care benefits by utilizing Participating Providers. When you go to a Participating Provider for an eye examination, you are assured of little or no out-of-pocket cost. When you purchase vision care hardware, such as frames and spectacle lenses or contact lenses, from a Participating Provider/Supplier, you may have no out-of-pocket costs, depending on your 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 your out-of-pocket costs and allow you to purchase most vision care hardware at fixed, reduced prices. You will receive a listing of the Providers that participate in the QCC Insurance Company’s Vision Care Program.

The program also provides benefits if you choose 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

A. EYE EXAMINATION SERVICES:
   Such services, performed by a Professional Provider, as defined in the section entitled Defined Terms, shall include, but are not limited to:
   
   1. Case history
   2. Visual acuity, near and far.
   3. External examination, including biomicroscopy or other magnified evaluation of the anterior chamber.
   4. Objective, subjective and ophthalmoscopic examinations.
   5. Binocular measure.
   6. Summary, findings, and recommendations.

B. HARDWARE

1. CONTACT LENS PRESCRIPTION AND FITTING SERVICES:
   Such services, performed by a Professional Provider shall include, but are not necessarily limited to:
   
   1. Keratometry, or “K” reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve.
2. Proper fitting of appropriate contact lenses, including the training of insertion and removal of trial contact lenses to the patient's corneas.

3. 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.

2. 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 patient’s face and the subsequent servicing (e.g., refitting, realigning, readjusting, tightening).

LIMITATIONS

1. In cases involving Covered Services in which the Professional Provider or Supplier and Covered Person elect to utilize photogrey or light sensitive lenses, the program may provide benefits providing the Covered Person qualifies for such benefits. See the Schedule of Benefits for the benefit allowance, if any.

2. Payment for frames, spectacle lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.
SECTION 5 - WHAT IS NOT COVERED

Except as specifically provided in this Booklet/Certificate, 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 Covered Person 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 Covered Person against losses for lenses or frames;
- For sunglasses not requiring a prescription; VDT eyeglasses, safety eyeglasses and safety goggles;
- For medical attention or surgical treatment of the eye;
- For diagnostic services, such as diagnostic 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 Covered Person’s employer without charge to the Covered Person;
- 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 Covered Person claims the benefits or compensation, unless the Covered Person is an owner or executive officer and claims an exemption permitted by law;
- For which a Covered Person 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 Covered Person’s Effective Date;
- Incurred after the date of termination of the Covered Person’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 Covered Person incurs no charge;

• In a facility performed by a Professional Provider or Supplier who in any case is compensated by the facility for similar Covered Services performed for patients;

• 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 Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

• For low vision aids;

• For eyeglass frames and contact lenses dispensed within the same Benefit Period by a Participating Provider;

• Other than specifically provided in the section entitled Vision Care Benefits of this Booklet-Certificate.
SECTION 6 - GENERAL INFORMATION

BENEFITS TO WHICH COVERED PERSONS ARE ENTITLED

1. The liability of the Carrier is limited to the benefits specified in the Group Contract.

2. No person other than a Covered Person is entitled to receive benefits under this benefit program.

3. Benefits for Covered Services will be provided only for services and supplies that are rendered by a Provider specified in the Defined Terms section of this Booklet/Certificate.

TERMINATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP IN THE GROUP

When a Covered Person ceases to be an Eligible Employee or Eligible Dependent, or the required contribution is not paid, the Covered Person’s coverage will terminate at the end of the last month for which payment was made. However, if benefits under this coverage are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person’s termination under the Group Contract, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under the Group Contract to be not more than 60 days before the first day of the month in which the Group notified the Carrier of such termination.

CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY

A Covered Person’s benefits under this benefit program may be extended after the date that person ceases to be a Covered Person under the Group Contract because of termination of employment or termination of membership in the Group. It will be extended if, on that date, the person is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the person remains Totally Disabled from any such illness or injury, but not beyond twelve months if the person ceases to be a Covered Person because the Group Contract ends.

The Carrier will provide benefits under the Group Contract during an extension as if the person were still a Covered Person. In addition, the Carrier will provide benefits only to the extent that other coverage for the Covered Services is not provided for 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)

This subsection, and the requirements of COBRA continuation, may or may not apply to the Group. You should contact your Employer to find out whether or not these continuation of coverage provisions apply.

For purposes of this subsection of your Booklet/Certificate, “qualified beneficiary” means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for group health benefits under this Plan as:

1. You, an active, covered Employee;
2. Your spouse; or
3. Your Dependent child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified beneficiary.
Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified beneficiary.

**If An Employee Terminates Employment or Has a Reduction of Work Hours:** If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

1. Your termination of employment was not due to gross misconduct; and
2. You are not entitled to Medicare.

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

**Extra Continuation for Disabled Qualified Beneficiaries:** If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary’s health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security’s determination of the qualified beneficiary’s disability before the earlier of:

1. The end of the 18 month continuation period; and
2. Sixty (60) days after the date the qualified beneficiary is determined to be disabled.

If, during the 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the Plan Administrator within thirty (30) days of such determination, and continuation will end, as explained in the “When Continuation Ends” paragraph of this subsection.

**If an Employee Dies:** If you die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months, subject to the “When Continuation Ends” paragraph of this subsection.

**If an Employee’s Marriage Ends:** If your marriage ends due to divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months, subject to the “When Continuation Ends” paragraph of this subsection.

**If an Employee Becomes Entitled to Medicare:** If you become entitled to Medicare after terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to thirty-six (36) months from the date the initial eighteen (18) month continuation period started, subject to the “When Continuation Ends” paragraph of this subsection.

If you become entitled to Medicare before terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent eighteen (18)-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to eighteen (18) months, but may be extended until thirty-six (36) months from the date you became entitled to Medicare, subject to the “When Continuation Ends” paragraph of this subsection.
If a Dependent Loses Eligibility: If your Dependent child’s group health benefits end due to his or her loss of dependent eligibility as defined in this booklet/certificate, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to thirty-six (36) months, subject to the “When Continued Ends” paragraph of this subsection.

Concurrent Continuations: If your Dependent who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the Dependent may elect to extend his or her eighteen (18) month continuation period to up to thirty-six (36) months, if during the eighteen (18) month continuation period the Dependent becomes eligible for thirty-six (36) months of group health benefits due to any of the reasons stated above.

The thirty-six (36) month continuation period starts on the date the initial eighteen (18) month continuation period started, and the two (2) continuation periods will run concurrently.

The Qualified Beneficiary’s Responsibilities: A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

1. Your divorce or legal separation from your spouse; or
2. Your Dependent child’s loss of Dependent eligibility, as defined in this booklet/certificate; and/or

The notice must be given to the Plan Administrator within sixty (60) days of either of these this events.

In addition, a disabled qualified beneficiary must notify the Plan Administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within thirty (30) days of such final determination.

The Employer’s Responsibilities. Your Employer must notify the Plan Administrator, in writing, of:

1. Your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
2. Your death;
3. Your entitlement to Medicare; or
4. Commencement of employer’s bankruptcy proceedings.

The notice must be given to the Plan Administrator no later than thirty (30) days of any of these events.

The Plan Administrator’s Responsibilities: The Plan Administrator must notify the qualified beneficiary, in writing, of:

1. His or her right to continue the group health benefits described in this Booklet/Certificate;
2. The monthly premium he or she must pay to continue such benefits; and
3. The times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within fourteen (14) days of:

- The date the Employer notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
- The date the qualified beneficiary notifies the Plan Administrator, in writing, of your divorce or legal separation from your spouse, or your Dependent child’s loss of eligibility.
The Employer’s Liability: Your Employer will be liable for the qualified beneficiary’s continued group health benefits to the same extent as, and in the place of, the Plan, if:

1. The plan administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above; or.

2. The Employer fails to remit a qualified beneficiary’s timely premium payment to the Plan on time, thereby causing the qualified beneficiary’s group health benefit to end.

Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within sixty (60) days of the date a qualified beneficiary receives notice of his or her continuation rights from the Plan Administrator as described above or sixty (60) days of the date the qualified beneficiary’s group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month’s premium in a timely manner.

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

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Employer. An additional charge of two percent (2%) of the total premium charge may also be required by the Employer.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional fifty percent (50%) of the total premium charge during the extra eleven (11) month continuation period.

If the qualified beneficiary fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

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

When Continuation Ends: A qualified beneficiary’s continued group health benefits under this coverage ends on the first to occur of the following:

1. With respect to continuation upon your termination of employment or reduction of work hours, the end of the eighteen (18) month period which starts on the date the group health benefits would otherwise end;

2. With respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional eleven (11) months of continuation, the earlier of:
   a. The end of the twenty-nine (29) month period which starts on the date the group health benefits would otherwise end; or
   b. The first day of the month which coincides with or next follows the date which is thirty (30) days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;
3. With respect to continuation upon your death, your divorce or legal separation, or the end of your covered Dependent’s eligibility, the end of the thirty-six (36) month period which starts on the date the group health benefits would otherwise end;

4. With respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
   a. After your termination of employment or reduction of work hours, the end of the thirty-six (36) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
   b. Before, your termination of employment or reduction of work hours where, during the eighteen (18) month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the eighteen (18) month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than thirty-six (36) months from the date you become entitled to Medicare.

5. The date this coverage ends;

6. The end of the period for which the last premium payment is made;

7. The date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;

8. The date he or she becomes entitled to Medicare.

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

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

CONTINUATION OF INCAPACITATED CHILD

If your unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you for over half of his support, you may apply to the Carrier to continue coverage of such child under this coverage upon such terms and conditions as the Carrier may determine. Coverage of such Dependent child shall terminate upon his or her 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 Carrier for the first time, the handicapped child must have been covered under the prior carrier and submit proof from the prior carrier that the child was covered as a handicapped person.

TIMELY FILING

The Carrier will not be liable under this coverage unless proper notice is furnished to the Carrier that Covered Services have been rendered to a Covered Person. 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 Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.
Your failure to give notice to the Carrier 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 Carrier 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 Covered Person agrees that any person or entity having information relating to any Services or Supplies for which benefits are claimed under this benefit program may furnish to the Carrier, upon its request, any information (including copies of records) relating to the illness or injury. In addition, the Carrier may furnish similar information to other entities providing similar benefits at their request. The Carrier shall provide to the Group, at the Group's request, any and all information regarding claims and charges submitted to the Carrier by Providers. The Parties understand that any information provided to the Group will be adjusted by the Carrier to prevent the disclosure of the identity of any Covered Person or other patient treated by said Providers. The Group shall reimburse the Carrier for the actual costs of preparing and providing said information. The Carrier shall provide the Group with such cost figure and obtain the Group's approval of such expense prior to incurring such costs.

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

When the Carrier needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Carrier 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 Covered Person.

**CLAIM FORMS**

The Carrier will furnish to the Covered Person making the claim, or to the Contractholder, for delivery to such Covered Person, such forms as are required for filing proof of loss.

**TIME OF PAYMENT OF CLAIMS**

All benefits payable under this benefit program will be payable not more than 60 days after receipt of proof.

**RIGHT TO RECOVER PAYMENTS IN ERROR**

If the Carrier should pay for any contractually excluded services through inadvertence or error, the Carrier maintains the right to seek recovery of such payment from the Professional Provider, Supplier or Covered Person to whom such payment was made.

**CONSUMER RIGHTS**

Each Covered Person 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 on your ID card.

**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.
COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider is solely the Covered Person’s.

2. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by Covered Persons. The Carrier is not liable for any act or omission of any Professional Provider or Supplier. The Carrier has no responsibility for a Professional Provider’s or Supplier’s failure or refusal to render Covered Services to a Covered Person.

AGENCY RELATIONSHIPS

The Group is the agent of the Member, not the Carrier.

IDENTIFICATION CARDS AND BENEFIT BOOKLETS/CERTIFICATES

The Carrier will provide the Identification Cards to Covered Persons or to the Group, depending on the direction of the Group. The Carrier will also provide to each Member of an Enrolled Group a benefit booklet/certificate describing the benefits provided under the Group Contract.

APPLICABLE LAW

The Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

MEMBER RIGHTS

A Member shall have no rights or privileges as to the benefits provided under this coverage except as specifically provided herein.

NOTICE

Any notice required under the Group Contract must be in writing. Notice given to a Member will be given to the Member in care of the Group, or sent to the Member’s last address furnished to the Carrier by the Group. The Group, the Carrier, or a Member may, by written notice, indicate a new address for giving notice.

SUBROGATION

In the event any service is provided or any payment is made to a Covered Person under this Contract, the Carrier shall be subrogated and succeed to the Covered Person’s rights of recovery therefore against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in the name of the Member. The Covered Person shall execute and deliver such instruments and take such other reasonable action as the Carrier may require to secure such rights. The Member shall do nothing to prejudice the rights given the Carrier by this Article without their consent.

The Covered Person shall pay the Carrier all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Contract and as permitted by law.

The Carrier’s right of subrogation shall be unenforceable when prohibited by law.

LIMITATIONS OF CARRIER LIABILITY

The Carrier shall not be liable for injuries or damage resulting from acts or omissions of any Officer or Employee of the Carrier or any Professional Provider or Supplier furnishing services or supplies to the Covered Person; nor shall the Carrier be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.
SECTION 7 - RESOLVING PROBLEMS (COMPLAINTS/APPEALS)

Member Complaint Process

The Carrier 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 Carrier 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 Carrier is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within thirty (30) days.

Member Appeal Process

Filing an Appeal. The Carrier maintains procedures for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Carrier 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 Carrier 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 Carrier as directed below to obtain a form for a member/enrollee to authorize an appeal by a 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 Carrier, as stated in the letter notifying the Member of the decision or as follows:

Member Appeals Department  Toll Free Phone: 1-888-671-5276
P.O. Box 41820  Toll Free Fax: 1-888-671-5274 or

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 or Medical Appropriateness and requests the Carrier 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 Carrier 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 and Medical Appropriateness, 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 Carrier, must be pre-certified 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 Carrier 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 Carrier 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 Carrier 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 decisionmaker(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 Appeal Committee described below will be comprised of one to three persons designated by the Carrier to act as decisionmaker(s) on the appeal. The Committee decisionmaker(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 his 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 appeal consists of one level of internal review for which the 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 Plan 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 Carrier’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 Carrier, 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 his 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 seventy-two (72) hours after receipt of the expedited appeal by the Carrier. The Member will be notified of the decision by telephone and a letter mailed in no more than seventy-two (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 Carrier’s internal appeal process.

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The policy and procedures for Member appeals may change due to changes that the Carrier 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.
Resources
For Your Well-Being
**Section Overview**

**Wellness Guidelines**

A message about your health .............................................................................................................................5.1
Recommendations birth – 20 years ...................................................................................................................5.2
Recommendations 21 years and older ...............................................................................................................5.3
Resources ...........................................................................................................................................................5.5
Tips to stay healthy and safe ..............................................................................................................................5.6
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**Healthy LifestylesSM**

Financial rewards ...............................................................................................................................................5.9
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Wellness Guidelines for All Ages

Take 5 minutes to review for you and your family

Live Healthy, Stay Safe
Thank you for choosing Independence Blue Cross.

Your health and wellness are important. It’s why we provide you with the Wellness Guidelines to help you and your family stay healthy. The Wellness Guidelines are a summary of recommendations based on the U.S. Preventive Services Task Force and other nationally recognized sources. These recommendations have also been reviewed by our network health care providers.

We encourage you to take the time to review these guidelines. Use them as a starting point for conversations with your and your child’s health care providers. Your health care provider may recommend alternatives to the information outlined in these Wellness Guidelines based on your specific needs and the history of health or illness in your family. For the most up-to-date Wellness Guidelines and for more resources on how to stay healthy, please visit our website at www.ibxpress.com.

We hope you will find the Wellness Guidelines both educational and useful in helping you and your family stay in the best of health.

Sincerely,

I. Steven Udvarhelyi, M.D.
Chief Medical Officer
## Recommendations*†
**Birth – 20 Years**

<table>
<thead>
<tr>
<th>Test/Screening</th>
<th>Birth – 10 Years</th>
<th>11 – 20 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History &amp; Physical</strong></td>
<td>First visit after birth: includes length, weight, head circumference, weight for length, developmental review, and psychosocial/behavioral assessment; newborn metabolic/hemoglobin screening if not done at birth and other screenings if at risk (blood pressure, hearing, vision)</td>
<td>Annually, including height, weight, BMI, blood pressure, developmental review, psychosocial/behavioral assessment; vision at 12, 15, and 18 years; and other screenings if at risk (hearing, hemoglobin or hematocrit, tuberculosis) Discuss tobacco, alcohol/drug use, environmental/occupational risk factors</td>
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<td></td>
<td>Well visits (until 3 years): by 1 month, then at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, including length/height, weight, head circumference until 24 months, weight for length until 18 months, then body mass index (BMI), developmental review, and psychosocial/behavioral assessment; developmental screening at 9, 18, and 30 months; hematocrit or hemoglobin screening at 12 months; autism screening at 18 and 24 months; and other screenings if at risk (blood pressure, hearing, lead, tuberculosis, vision)</td>
<td>Well visits (3-10 years): every year, including height, weight, BMI, blood pressure, developmental review, psychosocial/behavioral assessment; vision at 3 years; hearing and vision at 4, 5, 6, 8, and 10 years; and other screenings if at risk (hemoglobin or hematocrit, lead, tuberculosis)</td>
</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>Every 2 years starting at age 10 or start of puberty for overweight youths who also have 2 additional risk factors including family history of diabetes, abnormal cholesterol test, high blood pressure, polycystic ovarian syndrome in females, or being a member of a high-risk ethnic population (African American, Asian American, Latino, Native American, Pacific Islander)</td>
<td>Consider screening if at risk or starting at age 20 Risk factors include family history of early coronary heart disease and parental history of high cholesterol</td>
</tr>
<tr>
<td><strong>Cholesterol (fasting)</strong></td>
<td>If at risk, consider screening starting at 24 months</td>
<td>Consider screening if at risk or starting at age 20</td>
</tr>
<tr>
<td><em>total cholesterol, low-density lipoprotein (LDL), high-density lipoprotein (HDL), and triglycerides</em></td>
<td>Risk factors include family history of early coronary heart disease and parental history of high cholesterol</td>
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</tr>
<tr>
<td><strong>Pap test/Pelvic exam (females)</strong></td>
<td>Not nationally recommended for this age group</td>
<td>Start 3 years after onset of vaginal intercourse or by age 21; then every 1-2 years depending on type of test</td>
</tr>
<tr>
<td><strong>Sexually transmitted diseases</strong></td>
<td>Discuss with child’s health care provider as appropriate</td>
<td>Discuss prevention and screening as appropriate</td>
</tr>
<tr>
<td><strong>Depression/suicide</strong></td>
<td>Discuss needs and assessment with your child’s health care provider</td>
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</tbody>
</table>

*Your health care provider may suggest alternative tests/screenings other than those listed. Wellness Guidelines are constantly changing and these guidelines were current at the time of publishing. Please discuss your individual needs and the recommended Wellness Guidelines with your health care provider. For coverage information and questions, please contact Customer Service at the telephone number on your member ID card. Please refer to your health benefit contract for complete details of terms, limitations, and exclusions of your health care coverage.
†Pregnant members, please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® Program and on how to get more information on screenings specific to pregnancy.
# Recommendations*†

21 Years and Older

<table>
<thead>
<tr>
<th>Test/Screening</th>
<th>21 – 39 Years</th>
<th>40 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>History &amp; Physical</td>
<td>At age 21, then every 2 years</td>
<td>Every 1-2 years to age 65, then annually</td>
</tr>
<tr>
<td></td>
<td>Includes height, weight, BMI, blood pressure</td>
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<td></td>
<td>Discuss tobacco, alcohol/drug use, environmental/occupational risk factors</td>
<td>Discuss tobacco, alcohol/drug use, environmental/occupational risk factors,</td>
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<tr>
<td></td>
<td></td>
<td>screen for cognitive function, discuss need for hearing screening/vision screening with your health care provider</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>If at risk or as recommended by your health care provider</td>
<td>Every 3 years beginning at age 45, or more frequently if at risk, or as recommended by your health care provider</td>
</tr>
<tr>
<td></td>
<td>Adults at risk are overweight and have additional risk factors including physical inactivity, having a first-degree relative with diabetes, women who had diabetes during pregnancy or have polycystic ovarian syndrome, or being a member of a high-risk ethnic population (African American, Asian American, Latino, Native American, Pacific Islander)</td>
<td></td>
</tr>
<tr>
<td>Cholesterol (fasting)</td>
<td>Every 5 years starting at age 20</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>(total cholesterol, low-density lipoprotein [LDL], high-density lipoprotein [HDL], and triglycerides)</td>
<td></td>
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<tr>
<td>Colorectal cancer screening</td>
<td>Not nationally recommended for this age group</td>
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<td></td>
<td></td>
<td>Starting at age 50, follow one of these five testing schedules:</td>
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<tr>
<td></td>
<td></td>
<td>Every 10 years: Colonoscopy</td>
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<tr>
<td></td>
<td></td>
<td>or Every 5 years: Flexible sigmoidoscopy**</td>
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<tr>
<td></td>
<td></td>
<td>or Every 5 years: Double-contrast barium enema**</td>
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<tr>
<td></td>
<td></td>
<td>or Every 5 years: Computed tomography (CT) colonography** (virtual colonoscopy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Talk with your health care provider about an annual take-home multiple sample stool test** as another screening option (fecal occult blood test [FOBT] or fecal immunochemical test [FIT]). Stool tests are less likely to find polyps compared to the tests listed above, therefore the above tests are preferred. **Colonoscopy should be done if results are positive.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or Talk with your health care provider about an annual take-home multiple sample stool test** as another screening option (fecal occult blood test [FOBT] or fecal immunochemical test [FIT]). Stool tests are less likely to find polyps compared to the tests listed above, therefore the above tests are preferred. **Colonoscopy should be done if results are positive.</td>
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### Recommendations*†
#### 21 Years and Older

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<tr>
<th>Test/Screening</th>
<th>21 – 39 Years</th>
<th>40 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate screening (males)</td>
<td>Not nationally recommended for this age group</td>
<td>Starting at age 50, discuss screening options with your health care provider; if at high risk (African American men and men with a family history of a first-degree relative with prostate cancer diagnosed before age 65), discuss at age 45; if more than one first-degree relative was diagnosed with prostate cancer at an early age, screening can begin at age 40</td>
</tr>
<tr>
<td>Abdominal Aortic Aneurysm screening (males)</td>
<td>Not nationally recommended for this age group</td>
<td>Once for men aged 65-75 who have ever smoked</td>
</tr>
<tr>
<td>Mammography (females)</td>
<td>Not nationally recommended for this age group</td>
<td>Every 1-2 years</td>
</tr>
<tr>
<td>Pap test/Pelvic exam (females)</td>
<td>Start 3 years after onset of vaginal intercourse or by age 21; then every 1-2 years depending on the type of test; after age 30, testing may be decreased to every 2-3 years (after 3 normal Pap tests in a row); an acceptable alternative may be the human papilloma virus (HPV) DNA test PLUS cervical cytology (standard or liquid-based Pap test) every 3 years. It may be appropriate for women who have had a total hysterectomy to stop cervical cancer screening.</td>
<td>Every 1-2 years, depending on type of test, then every 2-3 years after 3 normal Pap tests in a row; an acceptable alternative may be the human papilloma virus (HPV) DNA test PLUS cervical cytology (standard or liquid-based Pap test) every 3 years. It may be appropriate for women who have had a total hysterectomy to stop cervical cancer screening. Note: After age 70, with 3 normal Pap tests in a row and no abnormal tests in last 10 years, or if total hysterectomy was done, discontinuation of screening may be appropriate.</td>
</tr>
<tr>
<td>Osteoporosis screening (females)</td>
<td>Not nationally recommended for this age group</td>
<td>Begin screening at age 60 if at increased risk (including weight &lt;154 pounds) for fractures, otherwise start screening at age 65</td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>Discuss prevention and screening with your health care provider</td>
<td></td>
</tr>
<tr>
<td>Depression/suicide</td>
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Resources

Information in this booklet is based on the following sources:

- Advisory Committee on Immunization Practices, www.cdc.gov/vaccines/recs/schedules
- American Cancer Society, www.cancer.org
- American Heart Association, www.americanheart.org
- Centers for Disease Control and Prevention, Body Mass Index (BMI), www.cdc.gov/nccdphp/dnpa/bmi
- Specialty Consultant Review

Additional Resources:

- Planning for Pregnancy, Centers for Disease Control and Prevention, Preconception Care Questions and Answers: www.cdc.gov/ncbddd/preconception/QandA.htm
- For Pregnant Members:
  Please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® Program and on how to get more information on screenings specific to pregnancy. As soon as you think you are pregnant, schedule your first prenatal appointment. An initial exam should be done within three months of pregnancy, with follow-up examinations as recommended by your health care provider.

Please be advised that once you access a website not maintained by Independence Blue Cross, these websites are maintained by organizations that Independence Blue Cross does not control. The websites are to be used as a reference for informational purposes only and are not intended to replace the care and advice of medical professionals. Independence Blue Cross is not responsible for the content or for validating the content, nor is it responsible for any changes or updates made. Once you link to a website not maintained by Independence Blue Cross, you are subject to the terms and conditions of that website, including, but not limited to, its privacy policy.
Wellness Guidelines*†

Tips to Stay Healthy and Safe

- Adhere to a healthy diet and maintain a healthy weight
- Practice regular physical activity as recommended by your health care provider
- Follow good oral hygiene, including tooth brushing with fluoride toothpaste, flossing daily, and regular dentist visits
- Avoid illegal drug use, tobacco use, and excessive alcohol use
- Adopt sensible sun protection/safety practices
- Use appropriate protective/safety practices
- Use appropriate protective/safety gear when engaged in recreational activities
- Ensure regular use of seat belts, car seats, and air bags as appropriate
- Store firearms, matches, medications, and toxic chemicals safely
- Keep the number for poison control handy, 1-800-222-1222
- Properly install, test, and maintain smoke/carbon monoxide detectors
- Use flame-retardant sleepwear for all children; maintain proper sleep environment/position for infants
- Evaluate your home for risk of falls and other injuries, especially if there are young children and/or older individuals in the home
- Keep your hot water heater at a temperature less than 120 degrees

*Your health care provider may suggest alternative tests/screenings other than those listed. Wellness Guidelines are constantly changing and these guidelines were current at the time of publishing. Please discuss your individual needs and the recommended Wellness Guidelines with your health care provider. For coverage information and questions, please contact Customer Service at the telephone number on your member ID card. Please refer to your health benefit contract for complete details of terms, limitations, and exclusions of your health care coverage.

†Pregnant members, please call 1-800-598-BABY (2229) for more information about enrolling in our Baby BluePrints® Program and on how to get more information on screenings specific to pregnancy.

Topics to Discuss With Your Health Care Provider

Make the most of each visit with your or your child’s health care provider. Bring a list of questions. We suggest:

- Discuss any individual or family health history that may impact your current health status
- Review any screening results such as: blood pressure, height, weight, body mass index (BMI), and cholesterol test
- Review taking medication safely and correctly; routinely review usage/dosage of medications, including over-the-counter and oral supplements such as herbs, vitamins, and minerals
- Check if all age-appropriate immunizations are up-to-date, including flu, pneumococcal, and tetanus vaccinations (see website in resources section for additional immunization recommendation)
- Discuss feelings of sadness and/or depression
- Review your risk of violence, signs of abuse, and neglect
- Review sleeping concerns and ways to reduce stress
- Review dental health for infants and children: preventing baby bottle tooth decay and fluoride supplements
- If sexually active, discuss birth control options, family planning, and ways to prevent sexually transmitted diseases
- Review if you are at increased risk for heart disease and if aspirin is recommended
- Review need for diabetes, vision, glaucoma, and bone density screenings
- Females: Ask about the benefits and limitations of breast self-exam
- Females: Ask about managing menopausal signs and symptoms and available treatment options
Wellness Guidelines for All Ages

As a member of Independence Blue Cross, you have access to a wide variety of resources to help keep you and your family in the best of health.

We hope you take advantage of the many services available to you through our Independence Blue Cross Healthy Lifestyles™ programs.

For more information on our Healthy Lifestyles™ programs:
Please visit our website at ibxpress.com, or call the Health Resource Center at 1-800-ASK-BLUE or 1-215-241-3367, TDD 1-888-857-4816, Monday through Friday, 8 a.m. to 6 p.m. EST.

www.ibxpress.com
Take advantage of:

- financial rewards
- decision support tools
- personal health coach

Healthy Lifestyles™ — programs for every stage of your health

We’re here for you every step of the way.
Enjoy financial rewards and incentives

Our unique Healthy Lifestyles programs offer cash rewards, discounts, information, and reminders designed to help you and your family lead healthier lives. These programs are easy to join and include:

**Cash rewards**

- up to $150 reimbursement on fitness center fees;*
- up to $200 reimbursement for successfully completing a smoking cessation program;*
- up to $200 back for the cost of a weight management program;*
- up to $25 back for each bike helmet you purchase for yourself or a covered dependent;
- up to $25 back for successfully completing an authorized CPR or first aid course;
- up to $50 back for a parenting class, $50 back on the purchase of a breast pump, and $100 back for a lactation consultant.

*These programs require enrollment.
Discounts

- up to 30 percent off alternative health services, such as massage therapy, acupuncture, and nutrition counseling;
- up to 40 percent off the purchase of more than 2,400 health and wellness products, plus free shipping;
- exclusive discounts on CorCell®,* a program that preserves your child’s umbilical cord blood — a vital resource that can help combat a variety of life-threatening diseases.

Information

- Personal Health Profile provides you with a detailed report on your possible health risks;
- stress management and better sleep informational kit;
- Baby BluePrints® maternity program provides a risk assessment, maternity nurse support, and information on what to expect during your pregnancy;
- adoption education services provide essential information and resources including books and specialty items.

Reminders

- educational reminders for members to schedule important preventive health screenings, such as mammograms, Pap tests, and colorectal screenings;
- special reminders and resource mailings to keep the whole family up to date on immunizations and vaccinations.

*Independence Blue Cross has a minority ownership interest in CorCell, Inc.’s parent company.

Visit ibx.com, or call 1-800-ASK-BLUE (1-800-275-2583).
When it comes to making decisions regarding your health care, you aren’t alone. We provide a comprehensive support system to help you with significant treatment decisions or everyday health concerns.

**Access to a Health Coach 24/7**

Your own personal Health Coach is available anytime to answer your questions and to help you make knowledgeable, confident decisions regarding your health care. Your Health Coach can provide:

- information on everyday health concerns, such as headaches and joint pain;
- help if you are facing a significant medical decision, such as treatment options for back pain, breast or prostate cancer, or surgery;
- personalized calls about your chronic condition or other health concerns;
- information to help you know the right questions to ask your doctor.

**Blue Distinction Centers℠**

The Blue Distinction Centers for specialty care are quality providers of **weight loss (bariatric) surgery, cardiac care, and transplant services** nationwide. Designated centers have extensive experience, meet rigorous quality standards, and consistently demonstrate positive results.
Online tools through ibxpress.com

Our convenient and secure website gives you access to pricing tools and health information, including:

- **Provider finder.** Find quality ratings, patient safety data, and hospital cost information for participating doctors and hospitals.

- **Treatment cost estimator.** Estimate the cost of services related to a specific condition or procedure, including doctor’s visits, medications, and tests, before you receive care.

- **Health plan selector.** Evaluate the right plan for your health care needs based on your health profile and the average cost of each service.

- **Prescription drug tools.** Compare costs of prescription drugs, locate participating pharmacies, request mail order prescription refills, and check drug-to-drug interactions.

Other tools and resources

Our full range of decision support tools also includes:

- **Health encyclopedia** — access to a well-organized encyclopedia of health topics — on the Web or through the mail;

- **Audio library** — more than 470 health care topics from arthritis and anxiety, to pneumonia and immunizations;

- **Decision support videos** — a wide variety of free informational videos/DVDs on topics such as weight loss surgery, coping with depression, chronic lower back pain, and breast cancer, that help you decide about important treatment options.

*Available only with Independence Blue Cross Prescription Drug coverage.

Visit [ibx.com](http://ibx.com), or call **1-800-ASK-BLUE** (1-800-275-2583).
Get personal support

From developing a care plan for treating your chronic disease to teaching you how to best control asthma, our ConnectionsSM Health Management Programs offer support to help you make the choices that are right for you.

Our Health Coaches will work side by side with you to help you understand your condition, provide coping strategies, and monitor your progress.

With Connections, you’ll:

- gain a better understanding of your health condition and the treatment options available to you;
- learn to communicate more effectively with your doctor regarding your health concerns;
- learn to recognize the early warning signs that your condition is getting worse and take steps to avoid long-term complications;
- receive personalized calls and reminder letters to keep you motivated and up to date on your care;
- benefit from a comprehensive support network that teaches you and your family how to better manage your condition with your doctors.
Connections℠ provides support for the following chronic conditions:

- asthma
- chronic obstructive pulmonary disease (COPD)
- congestive heart failure (CHF)
- coronary heart disease
- diabetes
- hypertension
- migraine

Connections℠ also provides resources and support for the following complex conditions:

- amyotrophic lateral sclerosis (ALS)
- chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- Crohn’s disease
- cystic fibrosis
- dermatomyositis
- Gaucher’s disease
- hemophilia
- multiple sclerosis
- myasthenia gravis
- Parkinson’s disease
- polymyositis
- rheumatoid arthritis
- scleroderma
- seizure disorders
- sickle cell disease
- systemic lupus erythematosus (SLE)
For questions and eligibility requirements, visit us at www.ibx.com, or call the Health Resource Center at 1-800-ASK-BLUE or 215-241-3367, TDD 1-888-857-4816, Monday through Friday, 8 a.m. to 6 p.m.
INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

“Protected health information” or “PHI” is information about you, including information about where you live, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:
- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

1 If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group’s privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

2 For purposes of this Notice, “Independence Blue Cross” refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc.

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.
This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members’ protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or “HIPAA”) Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

This Notice takes effect on April 14, 2003, and will remain in effect until we replace or modify it.

Copies of this Notice
You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice
The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law
The HIPAA Privacy Rule generally does not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)
In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.
Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other IBC affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available IBC health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: We may use your PHI to make a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose “summary health information” to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. “Summary health information” is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor’s group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.
Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and
- To health oversight agencies, to allow them to conduct audits and investigations of the health care system, to determine eligibility for government programs, to determine compliance with government program standards, and for certain civil rights enforcement actions.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
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- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

**Coroners, Medical Examiners, or Funeral Directors:** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

**Organ and Tissue Donation:** We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

**To Prevent a Serious Threat to Health or Safety:** As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

**Military and National Security:** We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

**Inmates:** If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

**Workers’ Compensation:** As part of your workers’ compensation claim, we may have to disclose your PHI to a worker’s compensation carrier.

**To You:** When you ask us to, we will disclose to you your PHI that is in a “designated record set.” Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called “Your Privacy Rights Concerning Your Protected Health Information.”

**To Your Personal Representative:** If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed IBC Personal Representative Designation Form or documentation that supports the person’s qualification according to state law (such as a power of attorney or guardianship). To request the IBC Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.
To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child’s PHI to you. However, we may be required to deny a parent’s access to a minor’s PHI according to applicable state law.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoke your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved IBC Authorization Form. To request the IBC Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)

You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved IBC form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy
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psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross’s vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an “Accounting”). Any accounting of disclosures will not include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request, in writing, that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all
or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber’s right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

**Right to a Paper Copy of This Notice:** You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

**Your Right to File a Privacy Complaint**
If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross’s privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your Member Identification Card, or you may contact the Privacy Office as follows:

Independence Blue Cross  
Privacy Office  
P.O. Box 41762  
Philadelphia, PA 19101 - 1762  
Fax: (215) 241-4023 or (888) 678-7006 (toll free)  
E-mail: Privacy@ibx.com  
Phone: (215) 241-4735 or (888) 678-7005 (toll free)
# OUT-OF-NETWORK CLAIM FORM

Please Mail To: Personal Choice Claims P.O. Box 890016 Camp Hill, PA 17089-0016

<table>
<thead>
<tr>
<th>MEMBER/PATIENT</th>
<th>I.D. NUMBER</th>
<th>GROUP NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESENT ADDRESS STREET</td>
<td>NEW ADDRESS</td>
<td>CITY</td>
</tr>
<tr>
<td>PATIENT'S NAME (First, Middle, Last)</td>
<td>RELATIONSHIP OF PATIENT TO MEMBER</td>
<td>SEX</td>
</tr>
<tr>
<td>☐ SELF ☐ SPOUSE ☐ CHILD ☐ HANDICAPPED DEPENDENT ☐ OTHER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, complete Part II:

<table>
<thead>
<tr>
<th>POLICYHOLDER'S NAME</th>
<th>BIRTH DATE</th>
<th>EMPLOYMENT STATUS OF POLICYHOLDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ACTIVE ☐ DISABLED ☐ RETIRED EFFECTIVE DATE:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RELATIONSHIP OF POLICYHOLDER TO MEMBER

<table>
<thead>
<tr>
<th>SELF ☐ SPOUSE ☐ CHILD ☐ OTHER</th>
<th>OTHER INSURANCE CARRIER'S NAME</th>
<th>IDENTIFICATION NO</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
</table>

### TYPE(S) OF COVERAGE

| ☐ HOSPITALIZATION ☐ MEDICAL-SURGICAL ☐ DENTAL ☐ VISION ☐ DRUG ☐ MAJOR MEDICAL |
| ☐ OTHER |

### CONTRACT COVERS

| ☐ POLICYHOLDER ONLY ☐ POLICYHOLDER AND SPOUSE ☐ POLICYHOLDER AND CHILD(REN) ☐ FAMILY |

### OTHER INSURANCE

- Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?
  - ☐ NO ☐ YES EFFECTIVE DATE: MEDICARE ID NUMBER

- Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?
  - ☐ NO ☐ YES EFFECTIVE DATE: MEDICARE ID NUMBER

If you answered "YES" to either of the above, give employment status of the member listed in Part I:

| ☐ ACTIVE ☐ RETIRED ☐ DISABLED |

### III. DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:

- **NAME OF DOCTOR TREATING INJURY/ILLNESS**
- **DATE OF FIRST SYMPTOMS**

A. ____________________________

B. ____________________________

(Attach additional information, if necessary)

- WERE SERVICES RELATED TO HOSPITALIZATION? ☐ NO ☐ YES If yes,
  - Give date of admission / /

Admitting Physician ____________________________

- WERE EXPENSES DUE TO AN ACCIDENT? ☐ NO ☐ YES If yes, give type/place of accident:
  - Give date of accident / /

- Auto ☐ Work ☐ Other (specify) ____________________________

### IV. AUTHORIZATION

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Blue Cross all medical or other information requested for the processing of this claim. I hereby agree to reimburse Blue Cross in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

<table>
<thead>
<tr>
<th>MEMBER'S SIGNATURE</th>
<th>DATE</th>
<th>(AREA CODE) HOME PHONE</th>
<th>(AREA CODE) WORK PHONE</th>
</tr>
</thead>
</table>

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INSTRUCTIONS:

Remember: Personal Choice Network providers will submit a claim for you. This claim form should only be used when you see an Out-Of-Network provider who does not submit a claim for you.

1. Attach all itemized bills to this claim form. Bills should include the following information:
   - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item.
   - PATIENT'S full name
   - DESCRIPTION of each service, or supply
   - DATE AND AMOUNT CHARGED for each service, or supply
   - DIAGNOSIS

2. When you have already paid the out-of-network provider in full for the services, or supplies you are claiming, payment should be made to you (if you are our member). Please be sure to have the provider mark "PAID IN FULL" clearly on the bill.

3. Please be sure that a PHYSICIAN'S MEDICAL CERTIFICATION accompanies bills for:
   - Purchase or Rental of Medical Equipment

4. If submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

5. Complete the entire claim form (have your physician complete the appropriate section, if necessary) and be sure to include the information requested above. This will avoid unnecessary delays in processing your claim. Keep a copy of this form and itemized bills for your records.

6. If you have QUESTIONS regarding the completion of this claim form, please contact Personal Choice Member Services at the telephone numbers shown on your id card.
Insert

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How to find a Davis Vision Participating Provider...

It’s easy! There are thousands of providers that participate with Davis Vision, including many in the local area. To locate a participating provider near you, simply call toll-free 1-888-393-2583 or go to www.ibx.com.